837 Health Care Claim: Institutional

HIPAA/V5010X223A1/837: 837 Health Care Claim: Institutional

Encounter Version: 1.0

Author: Edifecs, Inc

Company: Bureau of TennCare

Publication: 3/22/2011 Trading Partner: MCOs

Notes:

Table of Contents

Health Care Claim: Institutional	1
Billing Provider Specialty Information	11
Billing Provider Name	12
Payer Name	13
Claim information	14
Statement Dates	15
Payer Claim Control Number	16
File Information	17
Billing Note	18
Occurrence Span Information	19
Value Information	24
Other Subscriber Information	31
Claim Level Adjustments	32
Coordination of Benefits (COB) Payer Paid Amount	34
Claim Check Or Remittance Date	35
Other Payer Secondary Identifier	36
Other Payer Claim Control Number	37
Institutional Service Line	38
Date - Service Date	40
Drug Identification	41
Drug Quantity	42
Line Adjudication Information	43
Line Adjustment	45
Line Check or Remittance Date	47

i

837

Health Care Claim: Institutional

Functional Group=HC

Purpose: This X12 Transaction Set contains the format and establishes the data contents of the Health Care Claim Transaction Set (837) for use within the context of an Electronic Data Interchange (EDI) environment. This transaction set can be used to submit health care claim billing information, encounter information, or both, from providers of health care services to payers, either directly or via intermediary billers and claims clearinghouses. It can also be used to transmit health care claims and billing payment information between payers with different payment responsibilities where coordination of benefits is required or between payers and regulatory agencies to monitor the rendering, billing, and/or payment of health care services within a specific health care/insurance industry segment. For purposes of this standard, providers of health care products or services may include entities such as physicians, hospitals and other medical facilities or suppliers, dentists, and pharmacies, and entities providing medical information to meet regulatory requirements. The payer refers to a third party entity that pays claims or administers the insurance product or benefit or both. For example, a payer may be an insurance company, health maintenance organization (HMO), preferred provider organization (PPO), government agency (Medicare, Medicaid, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), etc.) or an entity such as a third party administrator (TPA) or third party organization (TPO) that may be contracted by one of those groups. A regulatory agency is an entity responsible, by law or rule, for administering and monitoring a statutory benefits program or a specific health care/insurance industry segment.

Heading:

Pos	<u>Id</u>	Segment Name	Req	Max Use	Repeat	<u>Notes</u>	<u>Usage</u>
0050	ST	Transaction Set Header	M	1			Required
0100	BHT	Beginning of Hierarchical Transaction	M	1			Required
LOOP ID - 1000A					<u>1</u>	N1/0200L	
0200	NM1	Submitter Name	O	1		N1/0200	Required
0450	PER	Submitter EDI Contact Information	О	2			Required
LOOP	ID - 1000	<u>DB</u>			<u>1</u>	N1/0200L	
0200	NM1	Receiver Name	O	1		N1/0200	Required

Detail:

Pos	<u>Id</u>	Segment Name	Req	Max Use	Repeat	<u>Notes</u>	<u>Usage</u>
LOOP	ID - 2000	<u>0A</u>	•		<u>>1</u>		
0010	HL	Billing Provider Hierarchical Level	M	1			Required
0030	PRV	Billing Provider Specialty Information	O	1			Situational
0100	CUR	Foreign Currency Information	O	1			Situational
LOOP	ID - 2010	0AA	•		<u>1</u>	N2/0150L	
0150	NM1	Billing Provider Name	O	1		N2/0150	Required
0250	N3	Billing Provider Address	O	1			Required
0300	N4	Billing Provider City, State, ZIP Code	O	1			Required
0350	REF	Billing Provider Tax Identification	O	1			Required
0400	PER	Billing Provider Contact Information	О	2			Situational
LOOP	ID - 2010	OAB			1	N2/0150L	
0150	NM1	Pay-to Address Name	O	1	_	N2/0150	Situational
0250	N3	Pay-To Address - ADDRESS	O	1			Required
0300	N4	Pay-to Address City, State, ZIP Code	O	1			Required

LOOP	ID - 2010	AC			1	N2/0150L	
0150	NM1	Pay-To Plan Name	0	1	7	N2/0150L N2/0150	Situational
0250	N3	Pay-To Plan Address	0	1		112/0150	Required
0300	N3 N4	Pay-To Plan Address Pay-To Plan City/State/Zip	0	1			Required
		Code					-
0350	REF	Pay-To Plan Secondary Identification	О	1			Situational
0350	REF	Pay-To Tax Identification Number	О	1			Required
LOOP	ID - 2000	<u>B</u>			<u>>1</u>	· ·	
0010	HL	Subscriber Hierarchical Level	M	1			Required
0050	SBR	Subscriber Information	O	1			Required
LOOP	ID - 2010	BA			<u>1</u>	N2/0150L	
0150	NM1	Subscriber Name	О	1	_	N2/0150	Required
0250	N3	Subscriber Address	O	1			Situational
0300	N4	Subscriber City, State, ZIP Code	О	1			Required
0320	DMG	Subscriber Demographic Information	О	1			Situational
0350	REF	Subscriber Secondary Identification	О	1			Situational
0350	REF	Property and Casualty Claim Number	О	1			Situational
LOOP	ID - 2010	BB			1	N2/0150L	
0150	NM1	Payer Name	O	1		N2/0150L	Required
0250	N3	Payer Address	0	1		1.2, 3150	Situational
0300	N4	Payer City, State, ZIP Code	O	1			Required
0350	REF	Payer Secondary Identification	0	3			Situational
0350	REF	Billing Provider Secondary Identification	O	1			Situational
LOOP	ID - 2300				100		
1300	CLM	Claim information	0	1	100		Situational
1350	DTP	Discharge Hour	0	1			Situational
1350	DTP	Statement Dates	0	1			Required
1350	DTP	Admission Date/Hour	0	1			Situational
1350			0	1			Situational
	DTP	Date - Repricer Received Date					
1400	CL1	Institutional Claim Code	0	1			Required
1550	PWK	Claim Supplemental Information	О	10			Situational
1600	CN1	Contract Information	O	1			Situational
1750	AMT	Patient Estimated Amount Due	О	1			Situational
1800	REF	Service Authorization Exception Code	О	1			Situational
			O	1			Situational
1800	REF	Referral Number	0				
1800 1800	REF REF	Referral Number Prior Authorization	0	1			Situational
							Situational Situational
1800	REF	Prior Authorization Payer Claim Control	O	1			

1800	REF	Investigational Device Exemption Number	O	5			Situational
1800	REF	Claim Identifier For Transmission Intermediaries	О	1			Situational
1800	REF	Auto Accident State	0	1			Situational
1800	REF	Medical Record Number	0	1			Situational
1800	REF	Demonstration Project	O	1			Situational
		Identifier					
1800	REF	Peer Review Organization (PRO) Approval Number	O	1			Situational
1850	K 3	File Information	O	10			Situational
1900	NTE	Claim Note	O	10			Situational
1900	NTE	Billing Note	O	1			Situational
2200	CRC	EPSDT Referral	O	1			Situational
2310	HI	Principal Diagnosis	O	1			Required
2310	HI	Admitting Diagnosis	O	1			Situational
2310	HI	Patient's Reason For Visit	O	1			Situational
2310	HI	External Cause of Injury	O	1			Situational
2310	HI	Diagnosis Related Group (DRG) Information	О	1			Situational
2310	HI	Other Diagnosis Information	O	2			Situational
2310	HI	Principal Procedure Information	О	1			Situational
2310	HI	Other Procedure Information	О	2			Situational
2310	HI	Occurrence Span Information	О	2			Situational
2310	HI	Occurrence Information	O	2			Situational
2310	HI	Value Information	O	2			Situational
2310	HI	Condition Information	O	2			Situational
2310	HI	Treatment Code Information	O	2			Situational
2410	HCP	Claim Pricing/Repricing Information	О	1			Situational
LOOP I	D - 2310	A			1	N2/2500L	
2500	NM1	Attending Provider Name	О	1	_	N2/2500	Situational
2550	PRV	Attending Provider Specialty Information	О	1			Situational
2710	REF	Attending Provider	O	4			Situational
		Secondary Identification					
LOOP I	D 2210	D.			1	N2/2500L	
2500	NM1	Operating Physician Name	O	1	<u> </u>	N2/2500L	Situational
2710	REF	Operating Physician Operating Physician	0	4		142/2300	Situational
2/10	KEI	Secondary Identification	U	4			Situational
		· · · · · · · · · · · · · · · · · · ·					
LOOP I					<u>1</u>	N2/2500L	
2500	NM1	Other Operating Physician Name	О	1		N2/2500	Situational
2710	REF	Other Operating Physician Secondary Identification	О	4			Situational
LOOP I	D - 2310	D			1	N2/2500L	
2500	NM1	Rendering Provider Name	О	1	<u> </u>	N2/2500L	Situational
2710	REF	Rendering Provider	0	4		112,2300	Situational
2,10	111	Secondary Identification	9	r			Situational
	_	-					
LOOP I					<u>1</u>	N2/2500L	
2500	NM1	Service Facility Location	O	1		N2/2500	Situational

		N					ı
2650	N3	Name Service Facility Location	O	1			Required
2030	143	Address	O	1			required
2700	N4	Service Facility Location City/State/ZIP	O	1			Required
2710	REF	Service Facility Secondary Identification	O	3			Situational
LOOP	ID - 2310)F			1	N2/2500L	
2500	NM1	Referring Provider Name	0	1	<u> </u>	N2/2500 N2/2500	Situational
2710	REF	Referring Provider	0	3		112/2300	Situational
		Secondary Identification					
LOOP	ID - 2320	,			10	N2/2900L	
2900	SBR	Other Subscriber Information	O	1	_	N2/2900	Situational
2950	CAS	Claim Level Adjustments	O	5			Situational
3000	AMT	Coordination of Benefits (COB) Payer Paid Amount	О	1			Situational
3000	AMT	Remaining Patient Liability	O	1			Situational
3000	AMT	Coordination of Benefits (COB) Total Non-covered Amount	0	1			Situational
3100	OI	Other Insurance Coverage Information	O	1			Required
3150	MIA	Inpatient Adjudication Information	O	1			Situational
3200	MOA	Outpatient Adjudication Information	О	1			Situational
LOOP	ID - 2330	<u>)A</u>			1	N2/3250L	
3250	NM1	Other Subscriber Name	O	1		N2/3250	Required
3320	N3	Other Subscriber Address	O	1			Situational
3400	N4	Other Subscriber City/State/ZIP Code	0	1			Required
3550	REF	Other Subscriber Secondary Information	0	2			Situational
LOOP	ID - 2330) <u>B</u>		·	1	N2/3250L	
3250	NM1	Other Payer Name	O	1	_	N2/3250	Required
3320	N3	Other Payer Address	O	1			Situational
3400	N4	Other Payer City/State/ZIP Code	O	1			Required
3500	DTP	Claim Check Or Remittance Date	O	1			Situational
3550	REF	Other Payer Secondary Identifier	О	2			Situational
3550	REF	Other Payer Prior Authorization Number	О	1			Situational
3550	REF	Other Payer Referral Number	О	2			Situational
3550	REF	Other Payer Claim Adjustment Indicator	О	1			Situational
3550	REF	Other Payer Claim Control Number	О	1			Situational
I OOD	ID - 2330	nc .			1	N2/3250L	
3250	NM1	Other Payer Attending Provider	О	1	1	N2/3250L	Situational
3550	REF	Other Payer Attending	O	4			Required

		Provider Secondary Identification					
LOOP	ID - 2330	D <u>D</u>	·		1	N2/3250L	
3250	NM1	Other Payer Operating Physician	О	1	_	N2/3250	Situational
3550	REF	Other Payer Operating Physician Secondary Identification	О	4			Required
LOOP	ID - 2330)F.			1	N2/3250L	
3250	NM1	Other Payer Other	0	1	_	N2/3250	Situational
		Operating Physician					
3550	REF	Other Payer Other Operating Physician Secondary Identification	О	4			Required
IOOP	ID - 2330	NE .	•		1	N2/3250L	
3250	NM1	Other Payer Service Facility Location	О	1	1	N2/3250L N2/3250	Situational
3550	REF	Other Payer Service Facility Location Secondary Identification	О	3			Required
LOOP	ID - 2330) <u>C</u>			1	N2/3250L	
3250	NM1	Other Payer Rendering Provider Name	О	1	<u> </u>	N2/3250	Situational
3550	REF	Other Payer Rendering Provider Secondary Identifier	О	4			Required
LOOD	ID 2220				1	N2/22501	
3250	ID - 2330 NM1	Other Payer Referring	O	1	1	N2/3250L N2/3250	Situational
		Provider				142/3230	
3550	REF	Other Payer Referring Provider Secondary Identification	0	3			Required
LOOP	ID - 2330	nt .			1	N2/3250L	
3250	NM1	Other Payer Billing Provider	O	1		N2/3250L	Situational
3550	REF	Other Payer Billing Provider Secondary Identifier	0	2		1(2/3230	Required
LOOP	ID - 2400				999	N2/3650L	
3650	LX	Service Line Number	O	1	223	N2/3650	Required
3750	SV2	Institutional Service Line	O	1		1.2,2000	Required
4200	PWK	Line Supplemental Information	0	10			Situational
4550	DTP	Date - Service Date	O	1			Situational
4700	REF	Line Item Control Number	O	1			Situational
4700	REF	Repriced Line Item Reference Number	O	1			Situational
4700	REF	Adjusted Repriced Line Item Reference Number	О	1			Situational
4750	AMT	Service Tax Amount	O	1			Situational
4750	AMT	Facility Tax Amount	O	1			Situational
4850	NTE	Third Party Organization Notes	О	1			Situational
4920	HCP	Line Pricing/Repricing Information	О	1			Situational

LOOP	ID - 2410		Ï		<u>1</u>	N2/4930L	
4930	LIN	Drug Identification	O	1		N2/4930	Situational
4940	CTP	Drug Quantity	O	1			Required
4950	REF	Prescription or Compound	O	1			Situational
		Drug Association Number					
LOOP	ID - 2420)A			1	N2/5000L	
5000	NM1	Operating Physician Name	O	1	-	N2/5000	Situational
5250	REF	Operating Physician	O	20			Situational
		Secondary Identification					
LOOD	ID - 2420	ND .			1	N2/5000L	
5000	<u>NM1</u>	Other Operating Physician	0	1	1	N2/5000L N2/5000	Situational
3000	INIVII	Name	O	1		112/3000	Situational
5250	REF	Other Operating Physician	O	20			Situational
0200	1121	Secondary Identification	Ü				Situational
LOOD	ID 2420				1	N/2/5000T	
5000	<u>ID - 2420</u> NM1		0	1	<u>1</u>	N2/5000L N2/5000	Situational
5250	REF	Rendering Provider Name Rendering Provider	0	20		11/2/3000	Situational Situational
3230	KEF	Secondary Identification	U	20			Situational
	<u> </u>					<u> </u>	
_	ID - 2420				<u>1</u>	N2/5000L	a
5000	NM1	Referring Provider Name	0	1		N2/5000	Situational
5250	REF	Referring Provider	O	20			Situational
		Secondary Identification					
LOOP	ID - 2430				<u>15</u>	N2/5400L	
5400	SVD	Line Adjudication	O	1		N2/5400	Situational
		Information	_	_			a.
5450	CAS	Line Adjustment	0	5			Situational
5500	DTP	Line Check or Remittance Date	O	1			Required
5505	AMT	Remaining Patient Liability	O	1			Situational
÷	÷	-		•			Situational
	ID - 2000		0	,	<u>>1</u>		G:
0010	HL	Patient Hierarchical Level	0	1			Situational
0070	PAT	Patient Information	0	1		310/04/207	Required
	ID - 2010		0	1	<u>1</u>	N2/0150L	Dagu-in- J
0150	NM1	Patient Name Patient Address	0	1		N2/0150	Required
0250	N3 N4	Patient Address Patient City/State/ZIP Code	0	1 1			Required
0300		Patient City/State/ZIP Code Patient Demographic	0	1			Required
0320	DMG	Information	U	1			Required
0350	REF	Property and Casualty	O	1			Situational
		Claim Number					
LOOP	ID - 2300				100		
1300	<u>CLM</u>	Claim information	0	1	100		Required
1350	DTP	Discharge Hour	O	1			Situational
1350	DTP	Statement Dates	0	1			Required
1350	DTP	Admission Date/Hour	0	1			Situational
	DTP	Date - Repricer Received	0	1			Situational
1330		Date	-				
1350			_				Required
1400	CL1	Institutional Claim Code	O	1			Required
	CL1 PWK	Claim Supplemental	0	10			Situational
1400 1550	PWK	Claim Supplemental Information	O				Situational
1400		Claim Supplemental					

		Due					
1800	REF	Service Authorization	O	1			Situational
1000	KLI	Exception Code	O	1			Situational
1800	REF	Referral Number	O	1			Situational
1800	REF	Prior Authorization	O	1			Situational
1800	REF	Payer Claim Control	O	1			Situational
		Number					
1800	REF	Repriced Claim Number	O	1			Situational
1800	REF	Adjusted Repriced Claim	O	1			Situational
		Number	_	_			
1800	REF	Investigational Device	O	5			Situational
1800	REF	Exemption Number Claim Identifier For	О	1			Situational
1600	KLI	Transmission Intermediaries	U	1			Situational
1800	REF	Auto Accident State	0	1			Situational
1800	REF	Medical Record Number	0	1			Situational
1800	REF	Demonstration Project	O	1			Situational
		Identifier					
1800	REF	Peer Review Organization	O	1			Situational
		(PRO) Approval Number	_				
1850	K3	File Information	0	10			Situational
1900	NTE	Claim Note	0	10			Situational
1900	NTE	Billing Note	0	1			Situational
2200	CRC	EPSDT Referral	0	1			Situational
2310	HI	Principal Diagnosis	0	1			Required
2310 2310	HI	Admitting Diagnosis Patient's Reason For Visit	O O	1			Situational Situational
2310	HI HI	External Cause of Injury	0	1 1			Situational Situational
2310	HI	Diagnosis Related Group	0	1			Situational
2310	111	(DRG) Information	U	1			Situational
2310	НІ	Other Diagnosis Information	O	2			Situational
2310	НІ	Principal Procedure	O	1			Situational
		Information					
2310	HI	Other Procedure	O	2			Situational
		Information					
2310	HI	Occurrence Span	O	2			Situational
2210		Information	0	2			G: · · ·
2310	HI	Occurrence Information	0	2			Situational
2310	HI	Value Information	0	2			Situational
2310 2310	Ш	Condition Information Treatment Code Information	O O	2 2			Situational Situational
2410	HI HCP	Claim Pricing/Repricing	0	1			Situational
∠ 4 10	ПСР	Information	U	1			Situatioliai
LOOP	D - 2310	•			1	N2/2500L	
2500	NM1	Attending Provider Name	О	1		N2/2500	Situational
2550	PRV	Attending Provider	O	1			Situational
		Specialty Information					
2710	REF	Attending Provider	O	4			Situational
		Secondary Identification					
LOOP	D - 2310)B		·	1	N2/2500L	
2500	NM1	Operating Physician Name	О	1	_	N2/2500	Situational
2710	REF	Operating Physician	0	4			Situational
		Secondary Identification					
LOOP	D - 2310	·			1	N2/2500L	
2500	NM1	Other Operating Physician	O	1	Ŧ	N2/2500L N2/2500	Situational
2500	1 41411	Said Operating Lilystelan	9			112/2300	Situational

2710	REF	Name Other Operating Physician Secondary Identification	0	4			Situational
LOOP	ID - 2310)D	·		1	N2/2500L	**
2500	NM1	Rendering Provider Name	О	1	_	N2/2500	Situational
2710	REF	Rendering Provider Secondary Identification	О	4			Situational
LOOP	ID - 231()E			1	N2/2500L	
2500	NM1	Service Facility Location Name	O	1	_	N2/2500	Situational
2650	N3	Service Facility Location Address	О	1			Required
2700	N4	Service Facility Location City/State/ZIP	О	1			Required
2710	REF	Service Facility Secondary Identification	О	3			Situational
LOOP	ID - 2310) <u>F</u>			1	N2/2500L	
2500	NM1	Referring Provider Name	О	1	_	N2/2500	Situational
2710	REF	Referring Provider	O	3			Situational
		Secondary Identification					
LOOP	ID - 2320	<u>)</u>			<u>10</u>	N2/2900L	
2900	SBR	Other Subscriber Information	О	1		N2/2900	Situational
2950	CAS	Claim Level Adjustments	O	5			Situational
3000	AMT	Coordination of Benefits (COB) Payer Paid Amount	O	1			Situational
3000	AMT	Remaining Patient Liability	O	1			Situational
3000	AMT	Coordination of Benefits (COB) Total Non-covered Amount	0	1			Situational
3100	OI	Other Insurance Coverage Information	O	1			Required
3150	MIA	Inpatient Adjudication Information	O	1			Situational
3200	MOA	Outpatient Adjudication Information	0	1			Situational
	ID - 2330				<u>1</u>	N2/3250L	
3250	NM1	Other Subscriber Name	0	1		N2/3250	Required
3320 3400	N3 N4	Other Subscriber Address Other Subscriber	0	1 1			Situational Required
3550	REF	City/State/ZIP Code Other Subscriber Secondary Information	О	2			Situational
							-
	ID - 233(0	1	<u>1</u>	N2/3250L	D . 1
3250	NM1	Other Payer Address	0	1		N2/3250	Required Situational
3320 3400	N3 N4	Other Payer Address Other Payer City/State/ZIP	0 0	1 1			Required
3500	DTP	Code Claim Check Or Remittance	0	1			Situational
3550	REF	Date Other Payer Secondary	0	2			Situational
3550	REF	Identifier Other Payer Prior	0	1			Situational
5550	NLI'	Authorization Number	5	1			Situational

3550	REF	Other Payer Referral Number	О	2			Situational
3550	REF	Other Payer Claim	O	1			Situational
3550	REF	Adjustment Indicator Other Payer Claim Control Number	О	1			Situational
LOOD	TD 2226					N/2/22 FOX	
	ID - 2330		0	1	<u>1</u>	N2/3250L	G' · · · · · · · · · · · · · · · · · · ·
3250	NM1	Other Payer Attending Provider	О	1		N2/3250	Situational
3550	REF	Other Payer Attending Provider Secondary Identification	0	4			Required
LOOP	ID - 2330				1	N2/3250L	
3250	NM1	Other Payer Operating Physician	O	1	=	N2/3250	Situational
3550	REF	Other Payer Operating Physician Secondary Identification	О	4			Required
LOOP	ID - 2330)F			1	N2/3250L	
3250	<u>NM1</u>	Other Payer Other	0	1		N2/3250L	Situational
3230	141411	Operating Physician	O	1		112/3230	Situational
3550	REF	Other Payer Other	O	4			Required
		Operating Physician					
		Secondary Identification					
LOOP ID - 2330F					1	N2/3250L	
3250	NM1	Other Payer Service Facility	О	1	_	N2/3250	Situational
		Location					
3550	REF	Other Payer Service Facility Location Secondary Identification	O	3			Required
LOOD	ID 2220				1	NI2/2250I	
3250	ID - 2330 NM1	Other Payer Rendering Provider Name	О	1	<u>1</u>	N2/3250L N2/3250	Situational
3550	REF	Other Payer Rendering Provider Secondary	О	4			Required
		Identifier					
LOOP	ID - 2330)Н			1	N2/3250L	
3250	NM1	Other Payer Referring Provider	O	1	_	N2/3250	Situational
3550	REF	Other Payer Referring	O	3			Required
		Provider Secondary Identification					·
LOOP	ID - 2330)I			1	N2/3250L	
3250	NM1	Other Payer Billing Provider	О	1		N2/3250	Situational
3550	REF	Other Payer Billing Provider	O	2			Required
		Secondary Identifier					•
LOOP	ID - 2400				999	N2/3650L	
3650	LX	Service Line Number	O	1	<u> </u>	N2/3650	Required
3750	SV2	Institutional Service Line	0	1		112/3030	Required
4200	PWK	Line Supplemental	0	10			Situational
.200		Information	-				
4550	DTP	Date - Service Date	O	1			Situational
4700	REF	Line Item Control Number	O	1			Situational

4700	REF	Repriced Line Item Reference Number	O	1			Situational
4700	REF	Adjusted Repriced Line	0	1			Situational
4700	KEF	Item Reference Number	U	1			Situational
4750	AMT	Service Tax Amount	О	1			Situational
4750	AMT	Facility Tax Amount	O	1			Situational
4850	NTE	Third Party Organization	O	1			Situational
		Notes					
4920	HCP	Line Pricing/Repricing	O	1			Situational
		Information					
LOOP	ID - 2410				<u>1</u>	N2/4930L	
4930	LIN	Drug Identification	O	1		N2/4930	Situational
4940	CTP	Drug Quantity	O	1			Required
4950	REF	Prescription or Compound	O	1			Situational
		Drug Association Number					
LOOP	ID - 2420)A			1	N2/5000L	
5000	NM1	Operating Physician Name	О	1	_	N2/5000	Situational
5250	REF	Operating Physician	O	20			Situational
		Secondary Identification					
LOOP	ID - 2420)R			1	N2/5000L	
5000	NM1	Other Operating Physician	O	1	<u> </u>	N2/5000	Situational
3000	111111	Name	O	1		112/3000	Situational
5250	REF	Other Operating Physician	O	20			Situational
		Secondary Identification					
LOOP	ID - 2420	OC.	<u> </u>		1	N2/5000L	
5000	NM1	Rendering Provider Name	0	1	-	N2/5000	Situational
5250	REF	Rendering Provider	0	20			Situational
		Secondary Identification					
LOOD	ID 2424)D			1	N/2/5000T	
5000	ID - 2420 NM1	Referring Provider Name	O	1	<u>1</u>	N2/5000L N2/5000	Situational
5250	REF	Referring Provider Name	0	20		N2/3000	Situational
3230	KEF	Secondary Identification	U	20			Situational
		· · · · · · · · · · · · · · · · · · ·	*				
<u>LOOP ID - 2430</u>					<u>15</u>	N2/5400L	
5400	SVD	Line Adjudication Information	O	1		N2/5400	Situational
5450	CAS	Line Adjustment	0	5			Situational
5500	DTP	Line Check or Remittance	0	1			Required
2300	211	Date	9	1			ricquired
5505	AMT	Remaining Patient Liability	O	1			Situational
5550	SE	Transaction Set Trailer	M	1			Required
3330	~_						

10

PRV Billing Provider Specialty Information

Pos: 0030 Max: 1
Detail - Optional

Loop:
2000A Elements: 3

User Option (Usage): Situational

Purpose: To specify the identifying characteristics of a provider

Element Summary:

Ref	<u>Id</u>	Element Name	Req	Type	Min/Max	<u>Usage</u>
PRV01	1221	Provider Code	M	ID	1/3	Required
		Description: Code identifying the type of pro	ovider			
PRV02	128	Reference Identification Qualifier	X	ID	2/3	Required
		Description: Code qualifying the Reference	Identific	cation		
PRV03	127	Reference Identification	X	AN	1/50	Required
		Description: Reference information as define	ed for a	particula	r Transaction S	Set or as specified

by the Reference Identification Qualifier

Encounter Notes:

Error Message: BILLING/PAY-TO PROVIDER MISSING - Loop Required by TennCare (2000A 8371)

Detail: PRV segment in Loop 2000A will be required.

NM1 Billing Provider Name

Pos: 0150 Max: 1
Detail - Optional
Loop:
2010AA Elements: 5

User Option (Usage): Required

Purpose: To supply the full name of an individual or organizational entity

Element Summary:

Ref	<u>Id</u>	Element Name	Req	Type	Min/Max	<u>Usage</u>
NM101	98	Entity Identifier Code	M	ID	2/3	Required
		Description: Code identifying an organization individual	nal enti	ty, a phy	sical location,	property or an
NM102	1065	Entity Type Qualifier	M	ID	1/1	Required
		Description: Code qualifying the type of entit	ity			
NM103	1035	Name Last or Organization Name	X	AN	1/60	Required
		Description: Individual last name or organization	ational 1	name		
NM108	66	Identification Code Qualifier	X	ID	1/2	Situational
		Description: Code designating the system/mcCode (67)	ethod of	f code str	ructure used for	r Identification
NM109	67	Identification Code	X	AN	2/80	Situational

Description: Code identifying a party or other code

Encounter Notes: Error Message: NPI MUST BE THE BILLING PROVIDER PRIMARY IDENTIFIER.

Detail: Excludes denied claims with ARC 107. If the Billing Provider is a HealthCare provider (not atypical), If 2010AA NM108 value is = XX and the 2010AA NM109 value is not 10 digits or does not contain a correct check digit, set edit. An atypical provider is identified by the taxonomy code in 2000/PRV03 where PRV01=BI and is defined as any on the taxonomy listing provided by TennCare in the "Taxonomy Codes with healthcare provider Indicator 20071016" document. These are defined by TennCare as healthcare providers and non-healthcare providers (the N values are Atypical).

NM1 Payer Name

Pos: 0150 Max: 1
Detail - Optional
Loop: Elements: 5

User Option (Usage): Required

Purpose: To supply the full name of an individual or organizational entity

Element Summary:

Ref	<u>Id</u>	Element Name	Req	Type	Min/Max	<u>Usage</u>
NM101	98	Entity Identifier Code	M	ID	2/3	Required
		Description: Code identifying an organization individual	onal enti	ty, a phy	sical location, p	property or an
NM102	1065	Entity Type Qualifier	M	ID	1/1	Required
		Description: Code qualifying the type of en	tity			
NM103	1035	Name Last or Organization Name	X	AN	1/60	Required
		Description: Individual last name or organization	zational	name		
NM108	66	Identification Code Qualifier	X	ID	1/2	Required
		Description: Code designating the system/n Code (67)	nethod o	f code str	ructure used for	Identification
NM109	67	Identification Code	X	AN	2/80	Required
		Description: Code identifying a party or oth	er code			
		Encounter Notes: Error Message: PAYER TennCare Required ID Number Is Missing (IBER INVALID -

Detail: If (837I: 2010BC/NM109 where NM101=PR) != 626001445, then set edit.

CLM Claim information

Pos: 1300 Max: 1
Detail - Optional
Loop:
2300 Elements: 7

User Option (Usage): Situational

Purpose: To specify basic data about the claim

Element Summary:

<u>Ref</u> CLM01	<u>Id</u> 1028	Element Name Claim Submitter's Identifier	Req M	<u>Type</u> AN	Min/Max 1/38	<u>Usage</u> Required	
		Description: Identifier used to track a claim payment	from cr	eation by	the health care	•	
CLM02	782	Monetary Amount	O	R	1/18	Required	
		Description: Monetary amount					
CLM05	C023	Health Care Service Location Information	О	Comp		Required	
		Description: To provide information that iderelated to the location at which a health care		•		ne type of bill	
CLM05-01	1331	Facility Code Value	M	AN	1/2	Required	
	Description: Code identifying where services were, or may be, performed; the first and second positions of the Uniform Bill Type Code for Institutional Services or the Place of Service Codes for Professional or Dental Services.						
CLM05-02	1332	Facility Code Qualifier	O	ID	1/2	Required	
		Description: Code identifying the type of facility referenced					
CLM05-03	1325	Claim Frequency Type Code	O	ID	1/1	Required	
		Description: Code specifying the frequency Uniform Billing Claim Form Bill Type Encounter Notes: Error Message: CLAIM Replacement Encounter Claims Are Not Pro Detail: If 2300/CLM05-3 is equal to "7", the	FREQU cessed I	IENCY C By TennC	ODE 7 IS NOT	ALLOWED -	
CLM07	1359	Provider Accept Assignment Code	О	ID	1/1	Required	
		Description: Code indicating whether the pr	ovider a	accepts as	signment		
CLM08	1073	Yes/No Condition or Response Code	O	ID	1/1	Required	
		Description: Code indicating a Yes or No co	ondition	or respon	nse		
CLM09	1363	Release of Information Code	O	ID	1/1	Required	
		Description: Code indicating whether the preparation authorizing the release of medical data			•	ment by the	
CLM20	1514	Delay Reason Code	O	ID	1/2	Situational	
		Description: Code indicating the reason why	y a requ	est was d	elayed		

DTP Statement Dates

Pos: 1350 Max: 1
Detail - Optional
Loop:
2300 Elements: 3

User Option (Usage): Required

Purpose: To specify any or all of a date, a time, or a time period

Element Summary:

<u>Ref</u>	<u>Id</u>	Element Name	Req	Type	Min/Max	<u>Usage</u>
DTP01	374	Date/Time Qualifier	M	ID	3/3	Required
		Description: Code specifying type of date of	r time, o	r both da	te and time	
DTP02	1250	Date Time Period Format Qualifier	M	ID	2/3	Required
		Description: Code indicating the date formation	at, time f	ormat, or	date and time	format
DTP03	1251	Date Time Period	M	AN	1/35	Required

Description: Expression of a date, a time, or range of dates, times or dates and times **Encounter Notes:** Error Message: DATE OF SERVICE CANNOT BE BEFORE DATE OF BIRTH - All services must take place on or after the date of birth (2010CA/DMG02 or 2010BA/DMG02)

Detail: Excludes denied claims with ARC 107. Date of service = 2300/DTP03 [8371: 2300/DTP03 (DTP01=434)], date of birth = 2010BA/DMG02 or 2010CA/DMG02. Error if date of birth is after date of service. All services must take place on or after the date of birth.

Error Message: HEADER SERVICE DATE MUST BE WITHIN DETAIL SERVICE DATES - The detail level dates if used must be within the range of the header dates.

Detail: Excludes denied claims with ARC 107. Check if 2400/DTP03 are within 2300/DTP03. This is a claim level edit. The detail level dates, if used, must be within the range of the header dates. If the claim service date is > the detail service date on the claim, an error will be reported. The dates are found in 2300/DTP03 (837I: DTP01=434).

Error Message: ENCOUNTER DATE OF SERVICE CANNOT BE GREATER THAN MCC RECEIPT DATE (2300/K301).

Detail: The edit applies to both dates in the 8371. If any service date (8371: 2300/DTP03 where DTP01=434 or 8371: 2400/DTP03 where DTP01=472) is greater than the MCC Receipt Date (2300/K301), then that service date is in error. The DTP02 should be inspected and if the DTP02=RD8, then the Begin date (the first date in the date range) should be used for comparing against the Receipt Date. For example, if the DTP segment looked like "DTP*472*RD8*20060911-20060922" the Service date would be "20060911".

REF Payer Claim Control Number

Pos: 1800 Max: 1
Detail - Optional
Loop:
2300 Elements: 2

User Option (Usage): Situational

Purpose: To specify identifying information

Element Summary:

<u>Ref</u>	<u>Id</u>	Element Name	Req	Type	Min/Max	<u>Usage</u>
REF01	128	Reference Identification Qualifier	M	ID	2/3	Required
		Description: Code qualifying the Reference	e Identifi	cation		
REF02	127	Reference Identification	X	AN	1/50	Required

Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier.

by the Reference Identification Qualifier

Encounter Notes: Error Message: REQUIRED ORIGINAL REFERENCE NUMBER MISSING - TennCare Requires a Voided Claim (CLM05-3 = 8) To Be Submitted With The Original Claim Number (REF02 when REF01 = F8).

Detail: If 2300/CLM05-3 = 8 and if no data in 2300/REF02 where REF01=F8, then set edit. If 2300/REF01=F8 segment is missing, set the edit.

K3 File Information

Pos: 1850 Max: 10
Detail - Optional

Loop:
2300 Elements: 1

User Option (Usage): Situational

Purpose: To transmit a fixed-format record or matrix contents

Element Summary:

<u>Ref</u>	<u>Id</u>	Element Name	<u>Req</u>	Type	Min/Max	<u>Usage</u>
K301	449	Fixed Format Information	M	AN	1/80	Required

Description: Data in fixed format agreed upon by sender and receiver

Encounter Notes: Error Message: ENCOUNTER DATE OF RECEIPT IS MISSING - TennCare Requires A Valid MCC Encounter Receipt Date (2300/K301). Valid format CCYYMMDD.

Detail: Edit should be applied to the 2300/K301 only. The edit should verify that the MCC Receipt Date (2300/K301) exists (MUST BE USED) and well formatted (Lexical format CCYYMMDD).

NTE Billing Note

Pos: 1900 Max: 1
Detail - Optional
Loop:
2300 Elements: 2

User Option (Usage): Situational

Purpose: To transmit information in a free-form format, if necessary, for comment or special instruction

Element Summary:

<u>Ref</u>	<u>Id</u>	Element Name	Req	Type	Min/Max	<u>Usage</u>
NTE01	363	Note Reference Code	O	ID	3/3	Required
		Description: Code identifying the functional	al area or	purpose	for which the i	note applies
NTE02	352	Description	M	AN	1/80	Required

Description: A free-form description to clarify the related data elements and their content **Encounter Notes:** *Error Message: REQUIRED CLAIM SEQUENCE NUMBER MISSING - TennCare sequencer is defined as the first subcomponent (NTE02-1) of the 2300 NTE02 where the NTE01 = ADD.*

Detail: 2300 NTE02 is Required for TennCare. The ONLY allowed NTE01 qualifier is 'ADD'. HIPAA defined standard element of length 80. The edit parses the NTE02 when NTE01 = "ADD", from the beginning of the element until either the segment terminator or the pipe symbol "\" is encountered. If the pipe symbol is encountered, all bytes following it until the segment terminator are the claim note and all bytes prior to the pipe are to be considered the Processing Sequence Identifier. If no pipe is found then the entire contents are considered Processing Sequence Identifier (80 bytes). This is a SNIP 1 error. The SNIP 7 error will set when the NTE02 is missing.

HI Occurrence Span Information

Pos: 2310 Max: 2
Detail - Optional

Loop:
2300 Elements: 12

User Option (Usage): Situational

Purpose: To supply information related to the delivery of health care

Element Summary:

Element	Jumme	a1 y •				
<u>Ref</u> HI01	<u>Id</u> C022	Element Name Health Care Code Information	Req M	<u>Type</u> Comp	Min/Max	<u>Usage</u> Required
		Description: To send health care codes and	their as	sociated o	lates, amounts	and quantities
HI01-01	1270	Code List Qualifier Code	M	ID	1/3	Required
		Description: Code identifying a specific inc	dustry co	de list		
HI01-02	1271	Industry Code	M	AN	1/30	Required
		Description: Code indicating a code from a	specific	industry	code list	
HI01-03	1250	Date Time Period Format Qualifier	X	ID	2/3	Required
		Description: Code indicating the date form	at, time	format, o	date and time	format
HI01-04	1251	Date Time Period	X	AN	1/35	Required
Description: Expression of a date, a time, or range of dates, times or dates and times Encounter Notes: Error Message: THE FROM DATE CANNOT BE AFTER THE TO DATE FOR OCCURRENCE SPAN CODES 1-12. Detail: Excludes denied claims with ARC 107. Occurrence span date = HI (01-12)-4 where HI(01-12)-1 = BI. If "FROM" date > "TO" date, then set edit.						
HI02	C022	Health Care Code Information	O	Comp		Situational
		Description: To send health care codes and	their as	sociated o	lates, amounts	and quantities
HI02-01	1270	Code List Qualifier Code	M	ID	1/3	Required
		Description: Code identifying a specific in	dustry co	de list		
HI02-02	1271	Industry Code	M	AN	1/30	Required
		Description: Code indicating a code from a	specific	industry	code list	
HI02-03	1250	Date Time Period Format Qualifier	X	ID	2/3	Required
		Description: Code indicating the date form	at, time	format, o	date and time	format
HI02-04	1251	Date Time Period	X	AN	1/35	Required
		Description: Expression of a date, a time, of Encounter Notes: <i>Error Message: THE F. FOR OCCURRENCE SPAN CODES 1-12.</i> Detail: Excludes denied claims with ARC 1	ROM DA	ATE CAN	NOT BE AFTE	R THE TO DATE
		HI(01-12)-1 = BI. If "FROM" date > "TO"				01 12) 1 where
HI03	C022	Health Care Code Information	O	Comp		Situational
		Description: To send health care codes and	their as	sociated o	lates, amounts	and quantities
HI03-01	1270	Code List Qualifier Code	M	ID	1/3	Required
		Description: Code identifying a specific in	dustry co	ode list		
HI03-02	1271	Industry Code	M	AN	1/30	Required
		Description: Code indicating a code from a	specific	industry	code list	

HI03-03	1250	Date Time Period Format Qualifier	X	ID	2/3	Required		
		Description: Code indicating the date forma	at, time f	ormat, or d	ate and time	format		
HI03-04	1251	Date Time Period	X	AN	1/35	Required		
		Description: Expression of a date, a time, or Encounter Notes: <i>Error Message: THE FR FOR OCCURRENCE SPAN CODES 1-12.</i>						
		Detail: Excludes denied claims with ARC 10 HI(01-12)-I = BI. If "FROM" date > "TO" of			n date = HI	(01-12)-4 where		
HI04	C022	Health Care Code Information	O	Comp		Situational		
		Description: To send health care codes and	their ass	sociated dat	es, amounts	and quantities		
HI04-01	1270	Code List Qualifier Code	M	ID	1/3	Required		
		Description: Code identifying a specific ind	lustry co	de list				
HI04-02	1271	Industry Code	M	AN	1/30	Required		
		Description: Code indicating a code from a	specific	industry co	ode list			
HI04-03	1250	Date Time Period Format Qualifier	X	ID	2/3	Required		
		Description: Code indicating the date format, time format, or date and time format						
HI04-04	1251	Date Time Period	X	AN	1/35	Required		
	Description: Expression of a date, a time, or range of dates, times or dates and times Encounter Notes: <i>Error Message: THE FROM DATE CANNOT BE AFTER THE TO DATE FOR OCCURRENCE SPAN CODES 1-12.</i>							
		Detail: Excludes denied claims with ARC 10 HI(01-12)-1 = BI. If "FROM" date > "TO" d			n date = HI	(01-12)-4 where		
HI05	C022	Health Care Code Information	O	Comp		Situational		
		Description: To send health care codes and	their ass	sociated dat	es, amounts	and quantities		
HI05-01	1270	Code List Qualifier Code	M	ID	1/3	Required		
		Description: Code identifying a specific ind	lustry co	de list				
HI05-02	1271	Industry Code	M	AN	1/30	Required		
		Description: Code indicating a code from a	specific	industry co	ode list			
HI05-03	1250	Date Time Period Format Qualifier	X	ID	2/3	Required		
		Description: Code indicating the date formation	at, time f	ormat, or d	ate and time	format		
HI05-04	1251	Date Time Period	X	AN	1/35	Required		
		Description: Expression of a date, a time, or Encounter Notes: <i>Error Message: THE FR FOR OCCURRENCE SPAN CODES 1-12.</i>						
		Detail: Excludes denied claims with ARC 10 HI(01-12)-1 = BI. If "FROM" date > "TO" of		-	n date = HI	(01-12)-4 where		
HI06	C022	Health Care Code Information	O	Comp		Situational		
		Description: To send health care codes and	their ass	sociated dat	es, amounts	and quantities		
HI06-01	1270	Code List Qualifier Code	M	ID	1/3	Required		
		Description: Code identifying a specific ind	lustry co	de list				
HI06-02	1271	Industry Code	M	AN	1/30	Required		
		Description: Code indicating a code from a	specific	industry co	ode list			

HI06-03	1250	Date Time Period Format Qualifier	X	ID	2/3	Required
		Description: Code indicating the date format,	, time	format, or d	ate and time f	ormat
HI06-04	1251	Date Time Period	X	AN	1/35	Required
		Description: Expression of a date, a time, or Encounter Notes: <i>Error Message: THE FRO FOR OCCURRENCE SPAN CODES 1-12.</i>				
		Detail: Excludes denied claims with ARC 107, HI(01-12)-1 = BI. If "FROM" date > "TO" date			n date = HI (0	01-12)-4 where
HI07	C022	Health Care Code Information	O	Comp		Situational
		Description: To send health care codes and the	heir as	sociated dat	es, amounts a	nd quantities
HI07-01	1270	Code List Qualifier Code	M	ID	1/3	Required
		Description: Code identifying a specific indu	stry co	ode list		
HI07-02	1271	Industry Code	M	AN	1/30	Required
		Description: Code indicating a code from a s	pecific	industry co	de list	
HI07-03	1250	Date Time Period Format Qualifier	X	ID	2/3	Required
		Description: Code indicating the date format	, time t	format, or d	ate and time f	ormat
HI07-04	1251	Date Time Period	X	AN	1/35	Required
Description: Expression of a date, a time, or range of dates, times or dates and times Encounter Notes: Error Message: THE FROM DATE CANNOT BE AFTER THE TO DATE FOR OCCURRENCE SPAN CODES 1-12. Detail: Excludes denied claims with ARC 107. Occurrence span date = HI (01-12)-4 where HI(01-12)-1 = BI. If "FROM" date > "TO" date, then set edit.						R THE TO DATE
HI08	C022	Health Care Code Information	O	Comp		Situational
		Description: To send health care codes and the	heir as	-	es, amounts a	
HI08-01	1270	Code List Qualifier Code	M	ID	1/3	Required
		Description: Code identifying a specific indu	stry co	ode list		•
HI08-02	1271	Industry Code	M	AN	1/30	Required
		Description: Code indicating a code from a s	pecific	industry co	de list	
HI08-03	1250	Date Time Period Format Qualifier	X	ID	2/3	Required
		Description: Code indicating the date format,	, time	format, or d	ate and time f	ormat
HI08-04	1251	Date Time Period	X	AN	1/35	Required
Description: Expression of a date, a time, or range of dates, times or dates and times Encounter Notes: Error Message: THE FROM DATE CANNOT BE AFTER THE TO DATE FOR OCCURRENCE SPAN CODES 1-12.						
		Detail: Excludes denied claims with ARC 107. HI(01-12)-1 = BI. If "FROM" date > "TO" da			n date = HI (0)	01-12)-4 where
HI09	C022	Health Care Code Information	O	Comp		Situational
		Description: To send health care codes and the	heir as	sociated dat	es, amounts a	nd quantities
HI09-01	1270	Code List Qualifier Code	M	ID	1/3	Required
		Description: Code identifying a specific indu	istry co	de list		
HI09-02	1271	Industry Code	M	AN	1/30	Required

		Description: Code indicating a code from a	specific	industry c	ode list	
HI09-03	1250	Date Time Period Format Qualifier	X	ID	2/3	Required
		Description: Code indicating the date formation	at, time	format, or o	late and time	format
HI09-04	1251	Date Time Period	X	AN	1/35	Required
		Description: Expression of a date, a time, o Encounter Notes: <i>Error Message: THE FIFOR OCCURRENCE SPAN CODES 1-12.</i>				
		Detail: Excludes denied claims with ARC 1 HI(01-12)-1 = BI. If "FROM" date > "TO"			ın date = HI	(01-12)-4 where
HI10	C022	Health Care Code Information	O	Comp		Situational
		Description: To send health care codes and	their as	sociated da	tes, amounts	and quantities
HI10-01	1270	Code List Qualifier Code	M	ID	1/3	Required
		Description: Code identifying a specific inc	dustry co	ode list		
HI10-02	1271	Industry Code	M	AN	1/30	Required
		Description: Code indicating a code from a	specific	industry c	ode list	
HI10-03	1250	Date Time Period Format Qualifier	X	ID	2/3	Required
		Description: Code indicating the date forms	at, time	format, or o	late and time	format
HI10-04	1251	Date Time Period	X	AN	1/35	Required
		Description: Expression of a date, a time, o Encounter Notes: <i>Error Message: THE FIFOR OCCURRENCE SPAN CODES 1-12.</i>				
		Detail: Excludes denied claims with ARC I HI(01-12)-1 = BI. If "FROM" date > "TO"			ın date = HI	(01-12)-4 where
HI11	C022	Health Care Code Information	O	Comp		Situational
		Description: To send health care codes and	their as	sociated da	tes, amounts	and quantities
HI11-01	1270	Code List Qualifier Code	M	ID	1/3	Required
		Description: Code identifying a specific inc	dustry co	ode list		
HI11-02	1271	Industry Code	M	AN	1/30	Required
		Description: Code indicating a code from a	specific	industry c	ode list	
HI11-03	1250	Date Time Period Format Qualifier	X	ID	2/3	Required
		Description: Code indicating the date formation	at, time	format, or o	late and time	format
HI11-04	1251	Date Time Period	X	AN	1/35	Required
		Description: Expression of a date, a time, o Encounter Notes: Error Message: THE FI				
		FOR OCCURRENCE SPAN CODES 1-12.				IK THE TO DATE
		POR OCCURRENCE SPAN CODES 1-12. Detail: Excludes denied claims with ARC 1 HI(01-12)-1 = BI. If "FROM" date > "TO"			nn date = HI	
HI12	C022	Detail: Excludes denied claims with ARC I			ın date = HI	
HI12	C022	Detail: Excludes denied claims with ARC I HI(01-12)-I = BI. If "FROM" date > "TO"	date, the O	en set edit. Comp		(01-12)-4 where Situational
HI12 HI12-01	C022	Detail: Excludes denied claims with ARC I HI(01-12)-1 = BI. If "FROM" date > "TO" of Health Care Code Information	date, the O	en set edit. Comp		(01-12)-4 where Situational
		Detail: Excludes denied claims with ARC 1 HI(01-12)-1 = BI. If "FROM" date > "TO" of Health Care Code Information Description: To send health care codes and	O their as	Comp sociated da	tes, amounts	(01-12)-4 where Situational and quantities

Description: Code indicating a code from a specific industry code list HI12-03 1250 **Date Time Period Format Qualifier** Required **Description:** Code indicating the date format, time format, or date and time format HI12-04 1251 **Date Time Period** X AN 1/35 Required **Description:** Expression of a date, a time, or range of dates, times or dates and times **Encounter Notes:** Error Message: THE FROM DATE CANNOT BE AFTER THE TO DATE FOR OCCURRENCE SPAN CODES 1-12. $Detail: \ Excludes \ denied \ claims \ with \ ARC \ 107. \ Occurrence \ span \ date = HI \ (01-12)-4 \ where$ HI(01-12)-1 = BI. If "FROM" date > "TO" date, then set edit.

HI Value Information

Pos: 2310 Max: 2
Detail - Optional
Loop:
2300 Elements: 12

User Option (Usage): Situational

Purpose: To supply information related to the delivery of health care

Element Summary:

<u>Ref</u> HI01	<u>Id</u> C022	Element Name Health Care Code Information	Req M	<u>Type</u> Comp	Min/Max	<u>Usage</u> Required	
		Description: To send health care codes and their associated dates, amounts and quantities					
HI01-01	1270	Code List Qualifier Code	M	ID	1/3	Required	
		Description: Code identifying a specific inde	ustry co	de list			
HI01-02	1271	Industry Code	M	AN	1/30	Required	
		Description: Code indicating a code from a specific industry code list Encounter Notes: Error Message: TENNCARE REQUIRES COVERED ACTUAL DAYS TO BE PRESENT WITH TOB 89X, EVEN IF COVERED ACTUAL DAYS IS ZERO.					
		Detail: TOB 89x (x is any valid value) Claim Quantity - 2300 Value Information segment present with value code "80" The value of zero is valid but the segment must be present.					
HI01-05	782	Monetary Amount	O	R	1/18	Required	
		Description: Monetary amount Encounter Notes: Error Message: MONETARY AMOUNT VALUE INVALID – TENNCARE DOES NOT ALLOW A NEGATIVE QUANTITY. Detail: If 2300 HI C022 (01 -12) -5 contains a negative value, reject the claim. Error Message: TOTAL DAYS BILLED INVALID. Detail: Excludes denied claims with ARC 107. IF ((Covered days + non-covered days = (statement to-date minus statement from-date)) THEN do not set the edit, ELSE IF (Covered days + non-covered days = (statement to-date minus statement from-date) + 1 or -1), do not set the edit. If any other condition, then set the edit. Statement period = 2300/DPT03 (to date minus from date) where DTP02=RD8 and DTP01=434. Covered days (where Value Code =					
11102	C022	variance of 0 or 1. The variance is allowed f			may count the a		
HI02	C022	Health Care Code Information Description: To send health care codes and to	O hair ass	Comp	atas amounts s	Situational nd quantities	
11102 01	1270	_	men ass M	ID		-	
HI02-01	1270	Code List Qualifier Code			1/3	Required	
11102 02	1071	Description: Code identifying a specific industry. Code	•		1/30	Daguinad	
HI02-02	1271	Industry Code Description: Code indicating a code from a	M	AN		Required	
		Description: Code indicating a code from a specific industry code list Encounter Notes: Error Message: TENNCARE REQUIRES COVERED ACTUAL DAYS TO BE PRESENT WITH TOB 89X, EVEN IF COVERED ACTUAL DAYS IS ZERO. Detail: TOB 89x (x is any valid value) Claim Quantity - 2300 Value Information segment present with value code "80" The value of zero is valid but the segment must be present.					
HI02-05	782	Monetary Amount	О	R	1/18	Required	
		Description: Monetary amount Encounter Notes: Error Message: MONET DOES NOT ALLOW A NEGATIVE QUANTI		MOUNT	VALUE INVAL		

Error Message: TOTAL DAYS BILLED INVALID. Detail: Excludes denied claims with ARC 107. IF ((Covered days + non-covered days = (statement to-date minus statement from-date)) THEN do not set the edit, ELSE IF (Covered $days + non-covered\ days = (statement\ to-date\ minus\ statement\ from-date) + 1\ or\ -1),\ do\ not$ set the edit. If any other condition, then set the edit. Statement period = 2300/DPT03 (to date minus from date) where DTP02=RD8 and DTP01=434. Covered days (where Value Code = 80) + non-covered days (Where Value Code = 81) must equal TO date - FROM date with a variance of 0 or 1. The variance is allowed for facilities that may count the discharge date. HI03 C022 **Health Care Code Information** Situational Comp Description: To send health care codes and their associated dates, amounts and quantities HI03-01 1270 **Code List Qualifier Code** M ID 1/3 Required Description: Code identifying a specific industry code list HI03-02 1271 **Industry Code** 1/30 Required Description: Code indicating a code from a specific industry code list **Encounter Notes:** Error Message: TENNCARE REQUIRES COVERED ACTUAL DAYS TO BE PRESENT WITH TOB 89X, EVEN IF COVERED ACTUAL DAYS IS ZERO. Detail: TOB 89x (x is any valid value) Claim Quantity - 2300 Value Information segment present with value code "80" The value of zero is valid but the segment must be present. HI03-05 782 1/18 **Monetary Amount** Required **Description:** Monetary amount **Encounter Notes:** Error Message: MONETARY AMOUNT VALUE INVALID – TENNCARE DOES NOT ALLOW A NEGATIVE QUANTITY. Detail: If 2300 HI C022 (01 -12) -5 contains a negative value, reject the claim. Error Message: TOTAL DAYS BILLED INVALID. Detail: Excludes denied claims with ARC 107. IF ((Covered days + non-covered days = (statement to-date minus statement from-date)) THEN do not set the edit, ELSE IF (Covered $days + non-covered\ days = (statement\ to-date\ minus\ statement\ from-date) + 1\ or\ -1),\ do\ not$ set the edit. If any other condition, then set the edit. Statement period = 2300/DPT03 (to date minus from date) where DTP02=RD8 and DTP01=434. Covered days (where Value Code = 80) + non-covered days (Where Value Code = 81) must equal TO date - FROM date with a variance of 0 or 1. The variance is allowed for facilities that may count the discharge date. HI04 C022 **Health Care Code Information** Comp Situational Description: To send health care codes and their associated dates, amounts and quantities HI04-01 **Code List Qualifier Code** 1270 1/3 Required **Description:** Code identifying a specific industry code list HI04-02 1271 М AN 1/30 Required **Industry Code Description:** Code indicating a code from a specific industry code list **Encounter Notes:** Error Message: TENNCARE REQUIRES COVERED ACTUAL DAYS TO BE PRESENT WITH TOB 89X, EVEN IF COVERED ACTUAL DAYS IS ZERO. Detail: TOB 89x (x is any valid value) Claim Quantity - 2300 Value Information segment present with value code "80" The value of zero is valid but the segment must be present. HI04-05 O R 782 **Monetary Amount** 1/18 Required **Description:** Monetary amount **Encounter Notes:** Error Message: MONETARY AMOUNT VALUE INVALID – TENNCARE DOES NOT ALLOW A NEGATIVE QUANTITY.

Error Message: TOTAL DAYS BILLED INVALID. Detail: Excludes denied claims with ARC 107. IF ((Covered days + non-covered days = (statement to-date minus statement from-date)) THEN do not set the edit, ELSE IF (Covered $days + non-covered\ days = (statement\ to-date\ minus\ statement\ from-date) + 1\ or\ -1),\ do\ not$ set the edit. If any other condition, then set the edit. Statement period = 2300/DPT03 (to date minus from date) where DTP02=RD8 and DTP01=434. Covered days (where Value Code = 80) + non-covered days (Where Value Code = 81) must equal TO date - FROM date with a variance of 0 or 1. The variance is allowed for facilities that may count the discharge date. HI05 C022 **Health Care Code Information** Situational Comp Description: To send health care codes and their associated dates, amounts and quantities HI05-01 1270 **Code List Qualifier Code** ID 1/3 Required Description: Code identifying a specific industry code list HI05-02 1271 **Industry Code** 1/30 Required Description: Code indicating a code from a specific industry code list **Encounter Notes:** Error Message: TENNCARE REQUIRES COVERED ACTUAL DAYS TO BE PRESENT WITH TOB 89X, EVEN IF COVERED ACTUAL DAYS IS ZERO. Detail: TOB 89x (x is any valid value) Claim Quantity - 2300 Value Information segment present with value code "80" The value of zero is valid but the segment must be present. HI05-05 782 1/18 **Monetary Amount** Required **Description:** Monetary amount **Encounter Notes:** Error Message: MONETARY AMOUNT VALUE INVALID – TENNCARE DOES NOT ALLOW A NEGATIVE QUANTITY. Detail: If 2300 HI C022 (01 -12) -5 contains a negative value, reject the claim. Error Message: TOTAL DAYS BILLED INVALID. Detail: Excludes denied claims with ARC 107. IF ((Covered days + non-covered days = (statement to-date minus statement from-date)) THEN do not set the edit, ELSE IF (Covered $days + non-covered\ days = (statement\ to-date\ minus\ statement\ from-date) + 1\ or\ -1),\ do\ not$ set the edit. If any other condition, then set the edit. Statement period = 2300/DPT03 (to date minus from date) where DTP02=RD8 and DTP01=434. Covered days (where Value Code = 80) + non-covered days (Where Value Code = 81) must equal TO date - FROM date with a variance of 0 or 1. The variance is allowed for facilities that may count the discharge date. HI06 C022 **Health Care Code Information** Situational Comp Description: To send health care codes and their associated dates, amounts and quantities HI06-01 **Code List Qualifier Code** 1270 1/3 Required **Description:** Code identifying a specific industry code list HI06-02 1271 М AN 1/30 Required **Industry Code Description:** Code indicating a code from a specific industry code list **Encounter Notes:** Error Message: TENNCARE REQUIRES COVERED ACTUAL DAYS TO BE PRESENT WITH TOB 89X, EVEN IF COVERED ACTUAL DAYS IS ZERO. Detail: TOB 89x (x is any valid value) Claim Quantity - 2300 Value Information segment present with value code "80" The value of zero is valid but the segment must be present. HI06-05 O 782 **Monetary Amount** R 1/18 Required **Description:** Monetary amount **Encounter Notes:** Error Message: MONETARY AMOUNT VALUE INVALID – TENNCARE DOES NOT ALLOW A NEGATIVE QUANTITY.

Error Message: TOTAL DAYS BILLED INVALID. Detail: Excludes denied claims with ARC 107. IF ((Covered days + non-covered days = (statement to-date minus statement from-date)) THEN do not set the edit, ELSE IF (Covered $days + non-covered\ days = (statement\ to-date\ minus\ statement\ from-date) + 1\ or\ -1),\ do\ not$ set the edit. If any other condition, then set the edit. Statement period = 2300/DPT03 (to date minus from date) where DTP02=RD8 and DTP01=434. Covered days (where Value Code = 80) + non-covered days (Where Value Code = 81) must equal TO date - FROM date with a variance of 0 or 1. The variance is allowed for facilities that may count the discharge date. HI07 C022 **Health Care Code Information** Situational Comp Description: To send health care codes and their associated dates, amounts and quantities HI07-01 1270 **Code List Qualifier Code** M ID 1/3 Required Description: Code identifying a specific industry code list HI07-02 1271 **Industry Code** 1/30 Required Description: Code indicating a code from a specific industry code list **Encounter Notes:** Error Message: TENNCARE REQUIRES COVERED ACTUAL DAYS TO BE PRESENT WITH TOB 89X, EVEN IF COVERED ACTUAL DAYS IS ZERO. Detail: TOB 89x (x is any valid value) Claim Quantity - 2300 Value Information segment present with value code "80" The value of zero is valid but the segment must be present. HI07-05 782 1/18 **Monetary Amount** Required **Description:** Monetary amount **Encounter Notes:** Error Message: MONETARY AMOUNT VALUE INVALID – TENNCARE DOES NOT ALLOW A NEGATIVE QUANTITY. Detail: If 2300 HI C022 (01 -12) -5 contains a negative value, reject the claim. Error Message: TOTAL DAYS BILLED INVALID. Detail: Excludes denied claims with ARC 107. IF ((Covered days + non-covered days = (statement to-date minus statement from-date)) THEN do not set the edit, ELSE IF (Covered $days + non-covered\ days = (statement\ to-date\ minus\ statement\ from-date) + 1\ or\ -1),\ do\ not$ set the edit. If any other condition, then set the edit. Statement period = 2300/DPT03 (to date minus from date) where DTP02=RD8 and DTP01=434. Covered days (where Value Code = 80) + non-covered days (Where Value Code = 81) must equal TO date - FROM date with a variance of 0 or 1. The variance is allowed for facilities that may count the discharge date. HI08 C022 **Health Care Code Information** Comp Situational Description: To send health care codes and their associated dates, amounts and quantities HI08-01 **Code List Qualifier Code** 1270 1/3 Required Description: Code identifying a specific industry code list HI08-02 1271 М AN 1/30 Required **Industry Code Description:** Code indicating a code from a specific industry code list **Encounter Notes:** Error Message: TENNCARE REQUIRES COVERED ACTUAL DAYS TO BE PRESENT WITH TOB 89X, EVEN IF COVERED ACTUAL DAYS IS ZERO. Detail: TOB 89x (x is any valid value) Claim Quantity - 2300 Value Information segment present with value code "80" The value of zero is valid but the segment must be present. HI08-05 O R 782 **Monetary Amount** 1/18 Required **Description:** Monetary amount **Encounter Notes:** Error Message: MONETARY AMOUNT VALUE INVALID – TENNCARE DOES NOT ALLOW A NEGATIVE QUANTITY.

Error Message: TOTAL DAYS BILLED INVALID. Detail: Excludes denied claims with ARC 107. IF ((Covered days + non-covered days = (statement to-date minus statement from-date)) THEN do not set the edit, ELSE IF (Covered $days + non-covered\ days = (statement\ to-date\ minus\ statement\ from-date) + 1\ or\ -1),\ do\ not$ set the edit. If any other condition, then set the edit. Statement period = 2300/DPT03 (to date minus from date) where DTP02=RD8 and DTP01=434. Covered days (where Value Code = 80) + non-covered days (Where Value Code = 81) must equal TO date - FROM date with a variance of 0 or 1. The variance is allowed for facilities that may count the discharge date. HI09 C022 **Health Care Code Information** Situational Comp Description: To send health care codes and their associated dates, amounts and quantities HI09-01 1270 **Code List Qualifier Code** M ID 1/3 Required Description: Code identifying a specific industry code list HI09-02 1271 **Industry Code** 1/30 Required Description: Code indicating a code from a specific industry code list **Encounter Notes:** Error Message: TENNCARE REQUIRES COVERED ACTUAL DAYS TO BE PRESENT WITH TOB 89X, EVEN IF COVERED ACTUAL DAYS IS ZERO. Detail: TOB 89x (x is any valid value) Claim Quantity - 2300 Value Information segment present with value code "80" The value of zero is valid but the segment must be present. HI09-05 782 1/18 **Monetary Amount** Required **Description:** Monetary amount **Encounter Notes:** Error Message: MONETARY AMOUNT VALUE INVALID – TENNCARE DOES NOT ALLOW A NEGATIVE QUANTITY. Detail: If 2300 HI C022 (01 -12) -5 contains a negative value, reject the claim. Error Message: TOTAL DAYS BILLED INVALID. Detail: Excludes denied claims with ARC 107. IF ((Covered days + non-covered days = (statement to-date minus statement from-date)) THEN do not set the edit, ELSE IF (Covered $days + non-covered\ days = (statement\ to-date\ minus\ statement\ from-date) + 1\ or\ -1),\ do\ not$ set the edit. If any other condition, then set the edit. Statement period = 2300/DPT03 (to date minus from date) where DTP02=RD8 and DTP01=434. Covered days (where Value Code = 80) + non-covered days (Where Value Code = 81) must equal TO date - FROM date with a variance of 0 or 1. The variance is allowed for facilities that may count the discharge date. HI10 C022 **Health Care Code Information** Comp Situational Description: To send health care codes and their associated dates, amounts and quantities HI10-01 **Code List Qualifier Code** 1270 1/3 Required **Description:** Code identifying a specific industry code list HI10-02 1271 М AN 1/30 Required **Industry Code Description:** Code indicating a code from a specific industry code list **Encounter Notes:** Error Message: TENNCARE REQUIRES COVERED ACTUAL DAYS TO BE PRESENT WITH TOB 89X, EVEN IF COVERED ACTUAL DAYS IS ZERO. Detail: TOB 89x (x is any valid value) Claim Quantity - 2300 Value Information segment present with value code "80" The value of zero is valid but the segment must be present. HI10-05 O R 782 **Monetary Amount** 1/18 Required **Description:** Monetary amount **Encounter Notes:** Error Message: MONETARY AMOUNT VALUE INVALID – TENNCARE DOES NOT ALLOW A NEGATIVE QUANTITY.

Error Message: TOTAL DAYS BILLED INVALID. Detail: Excludes denied claims with ARC 107. IF ((Covered days + non-covered days = (statement to-date minus statement from-date)) THEN do not set the edit, ELSE IF (Covered $days + non-covered\ days = (statement\ to-date\ minus\ statement\ from-date) + 1\ or\ -1),\ do\ not$ set the edit. If any other condition, then set the edit. Statement period = 2300/DPT03 (to date minus from date) where DTP02=RD8 and DTP01=434. Covered days (where Value Code = 80) + non-covered days (Where Value Code = 81) must equal TO date - FROM date with a variance of 0 or 1. The variance is allowed for facilities that may count the discharge date. HI11 C022 **Health Care Code Information** Situational Comp Description: To send health care codes and their associated dates, amounts and quantities HI11-01 1270 **Code List Qualifier Code** M ID 1/3 Required **Description:** Code identifying a specific industry code list HI11-02 1271 **Industry Code** 1/30 Required Description: Code indicating a code from a specific industry code list **Encounter Notes:** Error Message: TENNCARE REQUIRES COVERED ACTUAL DAYS TO BE PRESENT WITH TOB 89X, EVEN IF COVERED ACTUAL DAYS IS ZERO. Detail: TOB 89x (x is any valid value) Claim Quantity - 2300 Value Information segment present with value code "80" The value of zero is valid but the segment must be present. HI11-05 782 1/18 **Monetary Amount** Required **Description:** Monetary amount **Encounter Notes:** Error Message: MONETARY AMOUNT VALUE INVALID – TENNCARE DOES NOT ALLOW A NEGATIVE QUANTITY. Detail: If 2300 HI C022 (01 -12) -5 contains a negative value, reject the claim. Error Message: TOTAL DAYS BILLED INVALID. Detail: Excludes denied claims with ARC 107. IF ((Covered days + non-covered days = (statement to-date minus statement from-date)) THEN do not set the edit, ELSE IF (Covered $days + non-covered\ days = (statement\ to-date\ minus\ statement\ from-date) + 1\ or\ -1),\ do\ not$ set the edit. If any other condition, then set the edit. Statement period = 2300/DPT03 (to date minus from date) where DTP02=RD8 and DTP01=434. Covered days (where Value Code = 80) + non-covered days (Where Value Code = 81) must equal TO date - FROM date with a variance of 0 or 1. The variance is allowed for facilities that may count the discharge date. HI12 C022 **Health Care Code Information** Comp Situational Description: To send health care codes and their associated dates, amounts and quantities HI12-01 **Code List Qualifier Code** 1270 1/3 Required Description: Code identifying a specific industry code list HI12-02 1271 М AN 1/30 Required **Industry Code Description:** Code indicating a code from a specific industry code list **Encounter Notes:** Error Message: TENNCARE REQUIRES COVERED ACTUAL DAYS TO BE PRESENT WITH TOB 89X, EVEN IF COVERED ACTUAL DAYS IS ZERO. Detail: TOB 89x (x is any valid value) Claim Quantity - 2300 Value Information segment present with value code "80" The value of zero is valid but the segment must be present. HI12-05 O R 782 **Monetary Amount** 1/18 Required **Description:** Monetary amount **Encounter Notes:** Error Message: MONETARY AMOUNT VALUE INVALID – TENNCARE DOES NOT ALLOW A NEGATIVE QUANTITY.

Detail: If 2300 HI C022 (01 -12) -5 contains a negative value, reject the claim.

Error Message: TOTAL DAYS BILLED INVALID.

Detail: Excludes denied claims with ARC 107. IF ((Covered days + non-covered days = (statement to-date minus statement from-date)) THEN do not set the edit, ELSE IF (Covered days + non-covered days = (statement to-date minus statement from-date) + 1 or -1), do not set the edit. If any other condition, then set the edit. Statement period = 2300/DPT03 (to date minus from date) where DTP02=RD8 and DTP01=434. Covered days (where Value Code = 80) + non-covered days (Where Value Code = 81) must equal TO date - FROM date with a variance of 0 or 1. The variance is allowed for facilities that may count the discharge date.

SBR Other Subscriber Information

Pos: 2900 Max: 1
Detail - Optional
Loop:
2320 Elements: 5

User Option (Usage): Situational

Purpose: To record information specific to the primary insured and the insurance carrier for that insured

Element Summary:

Ref SBR01	<u>Id</u> 1138	Element Name Payer Responsibility Sequence Number Code	Req M	Type ID	<u>Min/Max</u> 1/1	<u>Usage</u> Required
		Description: Code identifying the insurance claim	carrier's	level of	responsibility	for a payment of a
SBR02	1069	Individual Relationship Code	O	ID	2/2	Required
		Description: Code indicating the relationship	betwee	en two in	dividuals or en	ntities
SBR03	127	Reference Identification	O	AN	1/50	Situational
		Description: Reference information as define by the Reference Identification Qualifier	ed for a	particula	r Transaction S	Set or as specified
SBR04	93	Name	O	AN	1/60	Situational
		Description: Free-form name				
SBR09	1032	Claim Filing Indicator Code	O	ID	1/2	Situational

Description: Code identifying type of claim

Encounter Notes: Error Message: Claim Filing Indicator Code Invalid, value of HM must be used

Detail: 2320/SBR09 must = HM, Health Maintenance Organization. Applies only to the MCC loop, not to Third Party Payer loops. The MCCID identifies the MCC loop as 2330B/REF02 when the 2330B/REF01=2U AND 2330B/REF02 has the first three bytes of MCC. If the 2330B loop does not contain this MCC ID, do not apply the edit to require the code.

CAS Claim Level Adjustments

Pos: 2950 Max: 5
Detail - Optional
Loop:
2320 Elements: 19

User Option (Usage): Situational

Purpose: To supply adjustment reason codes and amounts as needed for an entire claim or for a particular service within the claim being paid

Element Summary:

Element	Summ	ary:					
Ref	<u>Id</u>	Element Name	Req	Type	Min/Max	<u>Usage</u>	
CAS01	1033	Claim Adjustment Group Code	M	ID	1/2	Required	
		Description: Code identifying the general c	ategory	of payme	nt adjustment		
CAS02	1034	Claim Adjustment Reason Code	M	ID	1/5	Required	
		Description: Code identifying the detailed reason the adjustment was made Encounter Notes: <i>Error Message: VALUE OF ELEMENT CAS INCORRECT - ARC NOT ALLOWED BY TENNCARE</i>					
		Detail: All Adjustment Reason Codes must TennCare code list. TennCare Allowed: 1. Iv TennCare) 2. B2 - Reform counting covered TennCare (inactive) 4. 63 - Correction to a	07 - MC l service	C Denied (inactive	claim (differen 3. B19 - Refor	it use for	
CAS03	782	Monetary Amount	M	R	1/18	Required	
		Description: Monetary amount					
CAS04	380	Quantity	O	R	1/15	Situational	
		Description: Numeric value of quantity					
CAS05	1034	Claim Adjustment Reason Code	X	ID	1/5	Situational	
		Description: Code identifying the detailed reason the adjustment was made Encounter Notes: Error Message: VALUE OF ELEMENT CAS INCORRECT - ARC NOT ALLOWED BY TENNCARE Detail: All Adjustment Reason Codes must be valid according to national code list or TennCare code list. TennCare Allowed:1. 107 - MCC Denied claim (different use for TennCare) 2. B2 - Reform counting covered service (inactive) 3. B19 - Reform appeal for TennCare (inactive) 4. 63 - Correction to a Prior Claim (inactive)					
CAS06	782	Monetary Amount	X	R	1/18	Situational	
		Description: Monetary amount					
CAS07	380	Quantity	X	R	1/15	Situational	
		Description: Numeric value of quantity					
CAS08	1034	Claim Adjustment Reason Code	X	ID	1/5	Situational	
		Description: Code identifying the detailed reason the adjustment was made Encounter Notes: Error Message: VALUE OF ELEMENT CAS INCORRECT - ARC NOT ALLOWED BY TENNCARE Detail: All Adjustment Reason Codes must be valid according to national code list or TennCare code list. TennCare Allowed:1. 107 - MCC Denied claim (different use for TennCare) 2. B2 - Reform counting covered service (inactive) 3. B19 - Reform appeal for TennCare (inactive) 4. 63 - Correction to a Prior Claim (inactive)					
CAS09	782	Monetary Amount	X	R	1/18	Situational	
		Description: Monetary amount					
CAS10	380	Quantity	X	R	1/15	Situational	

		Description: Numeric value of quantity							
CAS11	1034	Claim Adjustment Reason Code	X	ID	1/5	Situational			
			Description: Code identifying the detailed reason the adjustment was made Encounter Notes: Error Message: VALUE OF ELEMENT CAS INCORRECT - ARC NOT ALLOWED BY TENNCARE						
		Detail: All Adjustment Reason Codes must be valid according to national code list or TennCare code list. TennCare Allowed: 1. 107 - MCC Denied claim (different use for TennCare) 2. B2 - Reform counting covered service (inactive) 3. B19 - Reform appeal for TennCare (inactive) 4. 63 - Correction to a Prior Claim (inactive)							
CAS12	782	Monetary Amount	X	R	1/18	Situational			
		Description: Monetary amount							
CAS13	380	Quantity	X	R	1/15	Situational			
		Description: Numeric value of quantity							
CAS14	1034	Claim Adjustment Reason Code	X	ID	1/5	Situational			
		Description: Code identifying the detailed reason the adjustment was made Encounter Notes: <i>Error Message: VALUE OF ELEMENT CAS INCORRECT - ARC NOT ALLOWED BY TENNCARE</i>							
		Detail: All Adjustment Reason Codes must be valid according to national code list or TennCare code list. TennCare Allowed: 1. 107 - MCC Denied claim (different use for TennCare) 2. B2 - Reform counting covered service (inactive) 3. B19 - Reform appeal for TennCare (inactive) 4. 63 - Correction to a Prior Claim (inactive)							
CAS15	782	Monetary Amount	X	R	1/18	Situational			
		Description: Monetary amount							
CAS16	380	Quantity	X	R	1/15	Situational			
		Description: Numeric value of quantity							
CAS17	1034	Claim Adjustment Reason Code	X	ID	1/5	Situational			
		Description: Code identifying the detailed re Encounter Notes: <i>Error Message: VALUE OF ALLOWED BY TENNCARE</i>							
		Detail: All Adjustment Reason Codes must be TennCare code list. TennCare Allowed:1. 107 TennCare) 2. B2 - Reform counting covered s TennCare (inactive) 4. 63 - Correction to a P	7 - MCC service (C Denied o (inactive) .	rlaim (differe 3. B19 - Refo	nt use for			
CAS18	782	Monetary Amount	X	R	1/18	Situational			
		Description: Monetary amount							
CAS19	380	Quantity	X	R	1/15	Situational			
		Description: Numeric value of quantity							

AMT Coordination of Benefits (COB) Payer Paid Amount

Pos: 3000 Max: 1
Detail - Optional
Loop:
2320 Elements: 2

User Option (Usage): Situational

Purpose: To indicate the total monetary amount

Element Summary:

<u>Ref</u>	<u>Id</u>	Element Name	Req	Type	Min/Max	<u>Usage</u>
AMT01	522	Amount Qualifier Code	M	ID	1/3	Required
		Description: Code to qualify amount				
AMT02	782	Monetary Amount	M	R	1/18	Required

Description: Monetary amount

Encounter Notes: Error Message: Capitated Claim (ARC 24) Not Allowed With Paid

Amount Greater Than Zero

Detail: Adjustment Reason Code (ARC) 24 is used by TennCare to indicate a capitated claim and/or detail. Placement of ARC 24 in the header CAS segment indicates that the entire claim is capitated. Capitated claims should not have a header or any detail paid amounts other than 0; otherwise, set a Normal edit. If a detail line is capitated – ARC 24 in detail level CAS - then the detail line should have a paid amount of 0; otherwise, set Normal edit status. If all details have an ARC 24 then the header is capitated and header level rules should apply. IF the 2330B loop REF01 = 2U where REF02 [1-3 bytes] = MCC. (This will eliminate non-MCC TPL loops).

Error Message: Denied Claim (ARC 107) Not Allowed With Paid Amount Greater Than Zero.

Detail: Adjustment Reason Code (ARC) 107 is used by TennCare to indicate a denied claim and/or detail. Placement of ARC 107 in the header CAS segment indicates that the entire claim is denied. Denied claims should not have a header or any detail paid amounts other than 0; otherwise, set a Normal edit. If a detail line is denied – ARC 107 in detail level CAS - then the detail line should have a paid amount of 0; otherwise, set Normal edit status. If all details have an ARC 107 then the header is denied and header level rules should apply. IF the 2330B loop REF01 = 2U where REF02 [1-3 bytes] = MCC. (This will eliminate non-MCC TPL loops)

Error Message: MCC PAID AMOUNT CANNOT BE GREATER THAN MCC ALLOWED AMOUNT - Allowed Amount 2320/AMT02.

Detail: Paid amount = 2320/AMT02 where AMT01=D(Payer Paid Amount). If paid amount > allowed amount, then error.

DTP Claim Check Or Remittance Date

Pos: 3500 Max: 1
Detail - Optional
Loop:
2330B Elements: 3

User Option (Usage): Situational

Purpose: To specify any or all of a date, a time, or a time period

Element Summary:

Ref	<u>Id</u>	Element Name	Req	Type	Min/Max	<u>Usage</u>
DTP01	374	Date/Time Qualifier	M	ID	3/3	Required
		Description: Code specifying type of date or	time, o	r both da	te and time	
DTP02	1250	Date Time Period Format Qualifier	M	ID	2/3	Required
		Description: Code indicating the date formation	t, time fo	ormat, or	date and time	format
DTP03	1251	Date Time Period	M	AN	1/35	Required

Description: Expression of a date, a time, or range of dates, times or dates and times **Encounter Notes:** *Error Message: REQUIRED MCC ADJUDICATION DATE MISSING - DATE 2330B/DTP03 Must Be Submitted (DTP01='573')*

Detail: Segment 2330B/DTP03 where DTP01=573 is required. This is mandatory for all transaction types. When the 2330B/DTP segment is missing, edit will set. Applies only to the MCC loop, not to Third Party Payer loops. The MCCID identifies the MCC loop as 2330B/REF02 when the 2330B/REF01=2U AND 2330B/REF02 has the first three bytes of MCC. If the 2330B loop does not contain this MCC ID, do not apply the edit to require MCC date.

Error Message: CLAIM ADJUDICATION DATE MUST BE GREATER THAN OR EQUAL TO FROM DATE OF SERVICE.

Detail: Adjudication Date edits apply only to the MCC loops. Edits do not apply to other payer loops. If any claim service from date (8371: 2300/DTP03 where DTP01=434) is greater than the MCC Claim Adjudication Date (2330B/DTP where DTP01=573), then the claim is in error. Flag the error at the 2330B DTP02. The DTP02 should be inspected and if the DTP02=RD8, then the Begin date (FROM Date - the first date in the date range) should be used for comparing against the Adjudication Date. For example, if the DTP segment looked like "DTP*472*RD8*20080911-20080922" the Service date would be "20080911".

Error Message: CLAIM ADJUDICATION DATE MUST BE GREATER THAN OR EQUAL TO THROUGH DATE OF SERVICE.

Detail: Adjudication Date edits apply only to the MCC loops. Edits do not apply to other payer loops. If any claim service 'through' date (8371: 2300/DTP03 where DTP01=434) is greater than the MCC Claim Adjudication Date (2330B/DTP where DTP01=573), then the claim is in error. Flag the error at the 2330B DTP02. The DTP02 should be inspected and if the DTP02=RD8, then the End date (the last date in the date range) should be used for comparing against the Adjudication Date. For example, if the DTP segment looked like "DTP*472*RD8*20080911-20080922" the Service date would be "20080922".

REF Other Payer Secondary Identifier

Pos: 3550 Max: 2
Detail - Optional
Loop:
2330B Elements: 2

User Option (Usage): Situational

Purpose: To specify identifying information

Element Summary:

<u>Ref</u>	<u>Id</u>	Element Name	<u>Req</u>	Type	Min/Max	<u>Usage</u>
REF01	128	Reference Identification Qualifier	M	ID	2/3	Required
		Description: Code qualifying the Reference	ce Identifi	cation		
REF02	127	Reference Identification	X	AN	1/50	Required

Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier

Encounter Notes: Error Message: REQUIRED ENCOUNTER SEGMENT MISSING - TennCare requires at least one 2330B/REF02 segment with REF01=2U for Encounter Claims.

Detail: Edit will verify that one REF segment at the 2330B level with a REF0I=2U, with the first 3 bytes = MCC, is present to indicate the MCC ID.

Error Message: MISSING OR INVALID TPL CARRIER CODE - NOT VALID FOR TENNCARE (Data in 2330B REF02 not on TennCare code list).

Detail: TennCare Requires the MCC to use valid Third Party Liability carrier codes when reporting TPL payments. Verify that the value submitted in 2330B/REF02 if REF01=2U is contained on the table. If not, set the edit. Must use TN table of carrier codes as a custom code list.

Other Payer Claim Control REF Number

Pos: 3550 Max: 1 **Detail - Optional** Loop: Elements: 2 2330B

User Option (Usage): Situational

Purpose: To specify identifying information

Element Summary:

Ref	<u>Id</u>	Element Name	Req	Type	Min/Max	<u>Usage</u>
REF01	128	Reference Identification Qualifier	M	ID	2/3	Required
		Description: Code qualifying the Reference	e Identifi	cation		
REF02	127	Reference Identification	X	AN	1/50	Required

Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier

Encounter Notes: Error Message: REQUIRED MCC ICN MISSING OR INVALID -2330B/REF02 Must Contain a Valid Internal Control Number

Detail: Mandatory element for MCC loop. If 2330B/REF02=0's or 9's or blank, If REF01 = F8. This edit should set if the qualifier is F8 and the REF02 is zeros or all nines or if missing. Applies only to the MCC loop, not to Third Party Payer loops. The MCCID identifies the MCC loop as 2330B/REF02 when the 2330B/REF01=2U AND 2330B/REF02 has the first three bytes of MCC. If the 2330B loop does not contain this MCC ID, do not apply the edit to require the ICN.

SV2 Institutional Service Line

Pos: 3750 Max: 1
Detail - Optional
Loop:
2400 Elements: 6

User Option (Usage): Required

Purpose: To specify the service line item detail for a health care institution

Element Summary:

<u>Ref</u> SV201	<u>Id</u> 234	Element Name Product/Service ID	Req X	Type AN	Min/Max 1/48	<u>Usage</u> Required
		Description: Identifying number for a produ	ict or se	rvice		
SV202	C003	Composite Medical Procedure Identifier	X	Comp		Situational
		Description: To identify a medical procedur modifiers	e by its	standardi	zed codes and	applicable
SV202-01	235	Product/Service ID Qualifier	M	ID	2/2	Required
		Description: Code identifying the type/source/source/service ID (234)	ce of the	e descript	ive number use	ed in
SV202-02	234	Product/Service ID	M	AN	1/48	Required
		Description: Identifying number for a produ	ict or se	rvice		
SV202-03	1339	Procedure Modifier	O	AN	2/2	Situational
	Description: This identifies special circumstances related to the performance of the service, as defined by trading partners					
SV202-04	1339	Procedure Modifier	O	AN	2/2	Situational
		Description: This identifies special circums defined by trading partners	tances re	elated to	the performanc	e of the service, as
SV202-05	1339	Procedure Modifier	O	AN	2/2	Situational
		Description: This identifies special circums defined by trading partners	tances re	elated to	the performanc	e of the service, as
SV202-06	1339	Procedure Modifier	O	AN	2/2	Situational
		Description: This identifies special circums defined by trading partners	tances re	elated to	the performanc	e of the service, as
SV202-07	352	Description	O	AN	1/80	Situational
		Description: A free-form description to clar	ify the r	elated da	ta elements and	d their content
SV203	782	Monetary Amount	O	R	1/18	Required
		Description: Monetary amount				
SV204	355	Unit or Basis for Measurement Code	X	ID	2/2	Required
		Description: Code specifying the units in which a measurement has been taken	hich a v	alue is be	ing expressed,	or manner in
SV205	380	Quantity	X	R	1/15	Required
		Description: Numeric value of quantity Encounter Notes: Error Message: ITEM D CLAIM - For Accommodation Revenue Code Must Equal Header Covered days(Where value)	e 0100 T	Through (
Detail: Excludes denied claims with ARC 107. Item Days = 2400/SV205. Covered days = Value Code 80. If the Item Days do not equal to covered days, then it is an error. The edit is limited to Accommodation Revenue codes of 0100-0219 or 1000-1005. All other codes should						

Situational

not set this edit. The edit will set if the sum of the units billed on the claim lines for any of the above revenue codes is not equal to the covered days in the header. If txn has days billed in the QTY segments (>0) but have no LX lines with Rev code 0100 - 0219 or 1000-1005, it should set the edit. If txn has Rev codes 0100 - 0219 or 1000-1005 and no QTY, or count doesn't match, then set the edit. If txn has no QTY segment and no Rev code with 0100 - 0219 or 1000-1005, then don't set the edit.

SV207 782 Monetary Amount

O R 1/18

Description: Monetary amount

DTP Date - Service Date

Pos: 4550 Max: 1
Detail - Optional
Loop:
2400 Elements: 3

User Option (Usage): Situational

Purpose: To specify any or all of a date, a time, or a time period

Element Summary:

Ref	<u>Id</u>	Element Name	Req	Type	Min/Max	<u>Usage</u>
DTP01	374	Date/Time Qualifier	M	ID	3/3	Required
		Description: Code specifying type of date o	r time, o	r both da	te and time	
DTP02	1250	Date Time Period Format Qualifier	M	ID	2/3	Required
		Description: Code indicating the date formation	it, time f	ormat, or	date and time	format
DTP03	1251	Date Time Period	M	AN	1/35	Required

Description: Expression of a date, a time, or range of dates, times or dates and times **Encounter Notes:** Error Message: DETAIL SERVICE DATES MUST BE WITHIN HEADER SERVICE DATE RANGE - Dates 2400/DTP03 Must Be Within Date Range In 2300/DTP03.

Detail: Excludes denied claims with ARC 107. Header service (statement) date = 2300/DTP03 where DTP01 = 434, Detail service date = 2400/DTP03 where DTP01 = 472). When the detail service date is same as header dates, no error should be reported.

Error Message: ENCOUNTER DATE OF SERVICE CANNOT BE GREATER THAN MCC RECEIPT DATE (2300/K301).

Detail: The edit applies to both dates in the 837I. If any service date (837I: 2300/DTP03 where DTP01=434 or 837I: 2400/DTP03 where DTP01=472) is greater than the MCC Receipt Date (2300/K301), then that service date is in error. The DTP02 should be inspected and if the DTP02=RD8, then the Begin date (the first date in the date range) should be used for comparing against the Receipt Date. For example, if the DTP segment looked like "DTP*472*RD8*20060911-20060922" the Service date would be "20060911".

LIN Drug Identification

Pos: 4930 Max: 1
Detail - Optional
Loop:
2410 Elements: 2

User Option (Usage): Situational

Purpose: To specify basic item identification data

Element Summary:

<u>Ref</u>	<u>Id</u>	Element Name	Req	Type	Min/Max	<u>Usage</u>
LIN02	235	Product/Service ID Qualifier	M	ID	2/2	Required
		Description: Code identifying the type/source Product/Service ID (234)	ce of the	descript	ive number used	d in
LIN03	234	Product/Service ID	M	AN	1/48	Required
		Description: Identifying number for a produ	ct or ser	vice		

Encounter Notes:

Error Message: NDC MISSING – TENNCARE REQUIRED (2410 LIN) WHEN HCPCS J-CODE IS PRESENT ON SERVICE LINE.

Detail: If 2400 SV2-2 or SV1-2 on the service line begins with an alpha J and no 2410 LIN is found on the same service line, set the edit. Exclude inpatient claims on the 837I.

CTP Drug Quantity

Pos: 4940 Max: 1
Detail - Optional
Loop:
2410 Elements: 2

User Option (Usage): Required **Purpose:** To specify pricing information

Element Summary:

Ref	<u>Id</u>	Element Name	Req	Type	Min/Max	<u>Usage</u>
CTP04	380	Quantity	X	R	1/15	Required
		Description: Numeric value of quantity				
CTP05	C001	Composite Unit of Measure	X	Comp		Required
		Description: To identify a composite unit of use)	measur	e (See Fi	gures Appendiz	x for examples of
CTP05-01	355	Unit or Basis for Measurement Code	M	ID	2/2	Required
		Description: Code specifying the units in wh which a measurement has been taken	nich a va	alue is be	ing expressed,	or manner in

Encounter Notes:

Error Message: 2410 CTP SEGMENT MISSING – REQUIRED BY TENNCARE WHEN THE HCPCS J-CODE IS PRESENT.

Detail: If a HCPCS J-Code is present in the service line with an NDC (2410 LIN03) the 2410 CTP segment is required on the same service line. Inpatient claims on 8371 should be excluded from this edit.

SVD Line Adjudication Information

Pos: 5400 Max: 1
Detail - Optional
Loop:
2430 Elements: 5

User Option (Usage): Situational

Purpose: To convey service line adjudication information for coordination of benefits between the initial payers of a health care claim and all subsequent payers

Element	Summary:
----------------	-----------------

Element Summary:							
Ref	<u>Id</u>	Element Name	Req	Type	Min/Max	<u>Usage</u>	
SVD01	67	Identification Code	M	AN	2/80	Required	
		Description: Code identifying a party or oth	er code				
SVD02	782	Monetary Amount	M	R	1/18	Required	
		Description: Monetary amount					
		Encounter Notes: Error Message: Capitate Amount Greater Than Zero	ed Clain	ı (ARC 2-	4) Not Allowed	With Paid	
		Detail: Adjustment Reason Code (ARC) 24 and/or detail. Placement of ARC 24 in the h is capitated. Capitated claims should not hat 0; otherwise, set a Normal edit. If a detail lithen the detail line should have a paid amoud details have an ARC 24 then the header is cothe 2330B loop REF01 = 2U where REF02 [MCC TPL loops). Error Message: Denied Claim (ARC 107) I Zero. Detail: Adjustment Reason Code (ARC) 107 and/or detail. Placement of ARC 107 in the claim is denied. Denied claims should not h than 0; otherwise, set a Normal edit. If a dethen the detail line should have a paid amoud etails have an ARC 107 then the header is a 2330B loop REF01 = 2U where REF02 [1-3 TPL loops)	eader Cove a hecone is cannot of 0; apitated 11-3 byte Not Alloward ave a hecont of 0; allowed ave a hecont of 0; alenied a	AS segmender or any pitated — otherwise and head wed With by Tenno CAS segmender or a dis denied otherwise and heade nd heade	ent indicates the y detail paid at ARC 24 in detail, set Normal ed ler level rules set. (This will ed Paid Amount Care to indicate the y detail paid in ARC 107 in east Normal ed r level rules she was detail paid in the y detail paid in the y set Normal ed r level rules she was detail paid in the y set Normal ed r level rules she was detail paid in the y set Normal ed r level rules she was detail paid in the y set Normal ed r level rules she was detail paid in the y set Normal ed r level rules she was detail paid in the y set Normal ed r level rules she was detail paid in the y detail paid i	at the entire claim amounts other than ail level CAS - dit status. If all hould apply. IF climinate non- Greater Than e a denied claim hat the entire amounts other detail level CAS - dit status. If all ould apply. IF the	
SVD03	C003	Composite Medical Procedure Identifier	О	Comp		Required	
		Description: To identify a medical procedur modifiers	e by its	standardi	zed codes and	applicable	
SVD03-01	235	Product/Service ID Qualifier	M	ID	2/2	Required	
		Description: Code identifying the type/source/source/service ID (234)	ce of the	e descript	ive number use	ed in	
SVD03-02	234	Product/Service ID	M	AN	1/48	Required	
		Description: Identifying number for a produ	ict or se	rvice			
SVD03-03	1339	Procedure Modifier	O	AN	2/2	Situational	
		Description: This identifies special circums defined by trading partners	tances re	elated to	the performanc	e of the service, as	
SVD03-04	1339	Procedure Modifier	O	AN	2/2	Situational	
		Description: This identifies special circums defined by trading partners	tances re	elated to	the performanc	e of the service, as	
SVD03-05	1339	Procedure Modifier	O	AN	2/2	Situational	

		Description: This identifies special circumstate defined by trading partners	ances re	elated to th	ne performan	ce of the service, as
SVD03-06	1339	Procedure Modifier	O	AN	2/2	Situational
		Description: This identifies special circumstate defined by trading partners	ances re	elated to th	ne performan	ce of the service, as
SVD03-07	352	Description	O	AN	1/80	Situational
		Description: A free-form description to clari	fy the r	elated data	a elements ar	d their content
SVD05	380	Quantity	O	R	1/15	Required
		Description: Numeric value of quantity				
SVD06	554	Assigned Number	O	N0	1/6	Situational
		Description: Number assigned for differential	ition wi	thin a tran	saction set	

CAS Line Adjustment

Pos: 5450 Max: 5
Detail - Optional
Loop:
2430 Elements: 19

User Option (Usage): Situational

Purpose: To supply adjustment reason codes and amounts as needed for an entire claim or for a particular service within the claim being paid

Element Summary:

<u>Ref</u>	<u>Id</u>	Element Name	Req	Type	Min/Max	<u>Usage</u>		
CAS01	1033	Claim Adjustment Group Code	M	ID	1/2	Required		
		Description: Code identifying the general category of payment adjustment						
CAS02	1034	Claim Adjustment Reason Code	M	ID	1/5	Required		
		Description: Code identifying the detailed reason the adjustment was made Encounter Notes: Error Message: VALUE OF ELEMENT CAS INCORRECT - ARC NOT ALLOWED BY TENNCARE						
		Detail: All Adjustment Reason Codes must be valid according to national code list or TennCare code list. TennCare Allowed: 1. 107 - MCC Denied claim (different use for TennCare) 2. B2 - Reform counting covered service (inactive) 3. B19 - Reform appeal for TennCare (inactive) 4. 63 - Correction to a Prior Claim (inactive)						
CAS03	782	Monetary Amount	M	R	1/18	Required		
		Description: Monetary amount						
CAS04	380	Quantity	O	R	1/15	Situational		
		Description: Numeric value of quantity						
CAS05	1034	Claim Adjustment Reason Code	X	ID	1/5	Situational		
		Encounter Notes: Error Message: VALUE OF ELEMENT CAS INCORRECT - ARC NOT ALLOWED BY TENNCARE Detail: All Adjustment Reason Codes must be valid according to national code list or TennCare code list. TennCare Allowed: 1. 107 - MCC Denied claim (different use for TennCare) 2. B2 - Reform counting covered service (inactive) 3. B19 - Reform appeal for TennCare (inactive) 4. 63 - Correction to a Prior Claim (inactive)						
CAS06	782	Monetary Amount	X	R	1/18	Situational		
		Description: Monetary amount						
CAS07	380	Quantity	X	R	1/15	Situational		
		Description: Numeric value of quantity						
CAS08	1034	Claim Adjustment Reason Code	X	ID	1/5	Situational		
		Description: Code identifying the detailed reason the adjustment was made Encounter Notes: Error Message: VALUE OF ELEMENT CAS INCORRECT - ARC NOT ALLOWED BY TENNCARE						
		Detail: All Adjustment Reason Codes must be valid according to national code list or TennCare code list. TennCare Allowed: 1. 107 - MCC Denied claim (different use for TennCare) 2. B2 - Reform counting covered service (inactive) 3. B19 - Reform appeal for TennCare (inactive) 4. 63 - Correction to a Prior Claim (inactive)						
CAS09	782	Monetary Amount	X	R	1/18	Situational		
		Description: Monetary amount						
CAS10	380	Quantity	X	R	1/15	Situational		

		Description: Numeric value of quantity						
CAS11	1034	Claim Adjustment Reason Code	X	ID	1/5	Situational		
		Description: Code identifying the detailed reason the adjustment was made Encounter Notes: <i>Error Message: VALUE OF ELEMENT CAS INCORRECT - ARC NOT ALLOWED BY TENNCARE</i>						
		Detail: All Adjustment Reason Codes must be valid according to national code list or TennCare code list. TennCare Allowed: 1. 107 - MCC Denied claim (different use for TennCare) 2. B2 - Reform counting covered service (inactive) 3. B19 - Reform appeal for TennCare (inactive) 4. 63 - Correction to a Prior Claim (inactive)						
CAS12	782	Monetary Amount	X	R	1/18	Situational		
		Description: Monetary amount						
CAS13	380	Quantity	X	R	1/15	Situational		
		Description: Numeric value of quantity						
CAS14	1034	Claim Adjustment Reason Code	X	ID	1/5	Situational		
		Description: Code identifying the detailed reason the adjustment was made Encounter Notes: Error Message: VALUE OF ELEMENT CAS INCORRECT - ARC NOT ALLOWED BY TENNCARE						
		Detail: All Adjustment Reason Codes must be valid according to national code list or TennCare code list. TennCare Allowed: 1. 107 - MCC Denied claim (different use for TennCare) 2. B2 - Reform counting covered service (inactive) 3. B19 - Reform appeal for TennCare (inactive) 4. 63 - Correction to a Prior Claim (inactive)						
CAS15	782	Monetary Amount	X	R	1/18	Situational		
		Description: Monetary amount						
CAS16	380	Quantity	X	R	1/15	Situational		
		Description: Numeric value of quantity						
CAS17	1034	Claim Adjustment Reason Code	X	ID	1/5	Situational		
		Description: Code identifying the detailed reason the adjustment was made Encounter Notes: <i>Error Message: VALUE OF ELEMENT CAS INCORRECT - ARC NOT ALLOWED BY TENNCARE</i>						
		Detail: All Adjustment Reason Codes must be valid according to national code list or TennCare code list. TennCare Allowed: 1. 107 - MCC Denied claim (different use for TennCare) 2. B2 - Reform counting covered service (inactive) 3. B19 - Reform appeal for TennCare (inactive) 4. 63 - Correction to a Prior Claim (inactive)						
CAS18	782	Monetary Amount	X	R	1/18	Situational		
		Description: Monetary amount						
CAS19	380	Quantity	X	R	1/15	Situational		
		Description: Numeric value of quantity						

DTP Line Check or Remittance Date

Pos: 5500 Max: 1
Detail - Optional
Loop:
2430 Elements: 3

User Option (Usage): Required

Purpose: To specify any or all of a date, a time, or a time period

Element Summary:

<u>Ref</u>	<u>Id</u>	Element Name	Req	Type	Min/Max	<u>Usage</u>
DTP01	374	Date/Time Qualifier	M	ID	3/3	Required
		Description: Code specifying type of date or	time, o	r both da	te and time	
DTP02	1250	Date Time Period Format Qualifier	M	ID	2/3	Required
		Description: Code indicating the date formation	t, time f	ormat, or	date and time	format
DTP03	1251	Date Time Period	M	AN	1/35	Required

Description: Expression of a date, a time, or range of dates, times or dates and times **Encounter Notes:** Error Message: SERVICE LINE ADJUDICATION DATE MUST BE GREATER THAN OR EQUAL TO FROM DATE OF SERVICE.

Detail: Adjudication Date edits apply only to the MCC loops. Edits do not apply to other payer loops. If any 'from' service date (8371: 2400/DTP03 where DTP01=472) is greater than the line adjudication date (2430/DTP where DTP01=573), then that date is in error. Flag the error at the 2430 DTP02. The DTP02 should be inspected and if the DTP02=RD8, then the Begin date (FROM-the first date in the date range) should be used for comparing against the Adjudication Date. For example, if the DTP segment looked like "DTP*472*RD8*20080911-20080922" the Service date would be "20080911".

Error Message: SERVICE LINE ADJUDICATION DATE MUST BE GREATER THAN OR EQUAL TO THROUGH DATE OF SERVICE.

Detail: Adjudication Date edits apply only to the MCC loops. Edits do not apply to other payer loops. If any end (FROM) service date (8371: 2400/DTP03 where DTP01=472) is greater than the line adjudication date (2430/DTP where DTP01=573), then that date is in error. Flag the error at the 2430 DTP02. The DTP02 should be inspected and if the DTP02=RD8, then the END date (the last date in the date range) should be used for comparing against the Adjudication Date. For example, if the DTP segment looked like "DTP*472*RD8*20080911-20080922" the Service date would be "20080922".